



Health Services
LOS ANGELES COUNTY

Risk Management Workforce Member Handbook



Preface

All things related to healthcare have risks. The goal of risk management and patient safety is to alleviate these risks by maintaining a safe and effective health care environment for patients, visitors, medical staff, and employees. Risk management and patient safety practices are designed to reduce the frequency and severity of adverse events in terms of human injury and financial loss and to identify opportunities to prevent these adverse events before they occur.

The Health Services Administration Quality Improvement and Patient Safety Program has developed this handbook to encourage your partnership in risk management and patient safety practices. It has been designed to serve as a resource in your daily practice and to be a guide for reporting near misses and adverse events.

The County of Los Angeles, Department of Health Services is committed to improving healthcare quality in County health facilities. Through continuous efforts and dedication to patient and employee safety, injuries and damages can be minimized and we can achieve our patient safety goals.

The Los Angeles County Department of Health Services
Quality Improvement & Patient Safety Program
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Los Angeles, CA 90012



Health Services
LOS ANGELES COUNTY

Risk Management
Workforce Member Handbook

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Quality Improvement & Patient Safety Program**

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www.patientsafety@dhs.lacounty.gov

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Introduction

Your facility's Risk Management Department works with the Los Angeles County Department of Health Services (LACDHS) Quality Improvement and Patient Safety Program (QIPS) to identify, evaluate, and reduce the risk of injury to patients, personnel, and visitors of our health care facilities. Prevention of patient injury, through early and appropriate response to current and potential problems, is the key to patient safety. Continued improvement in patient safety is attainable only through establishing a culture of safety and open communication in which these current and potential problems can be quickly and easily reported.

The goals of the Risk Management Department are to:

- Ensure timely identification, reporting, and investigation of near misses, unusual occurrences and adverse events;
- Recognize opportunities to prevent patient harm from the above events;
- Analyze service delivery systems to identify system weaknesses that may lead to a compromise in patient safety;
- Educate workforce members in the causation of risk management events to prevent them from recurring, and;
- Develop and enhance a culture of safety

Support and participation of all workforce members is necessary to achieve these goals. This booklet has been prepared to assist you in supporting our Risk Management Program goals and to provide awareness of some medical-legal issues you may face as a healthcare provider. Additional information related to risk management issues within LACDHS can be found on the QIPS intranet website located at <https://intranet.ladhs.org/qrs>. Questions involving medical-legal or patient safety issues can also be e-mailed to QIPS at patientsafety@dhs.lacounty.gov.

Event Notification

Your facility's Risk Management Program depends on information reported by all members of your worksite team. The purpose of reporting is to allow the designated staff to begin investigation of an event, to alert others to potentially adverse events so that further injuries are avoided, and to plan for potential economic loss from a liability exposure.

In 2006, LACDHS implemented the electronic Patient Safety Net (PSN) system for reporting both near misses and actual events. All of the LACDHS facilities have computers with access to the PSN system. Should the PSN system be inaccessible, workforce members may use either handwritten/hard copy reports or telephone/verbal reports. Events should always be entered into the PSN system when operable and include as many details as possible.

ADVERSE EVENTS & ERRORS

Adverse events are defined as those incidents in which a person receiving care is harmed. The adverse event may or may not be related to an error. An error is defined as the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim with actual or potential negative consequences for the patient. Workforce members who become aware of an adverse event or error involving a patient, visitor, or other workforce member, that may compromise safety, are expected to report it as soon as possible. (See LACDHS policies 311.2, 311.202,

and 311.203 for more information on reporting events.) The Risk Manager may then decide if the event meets the criteria for a Critical Clinical Event, California Department of Public Health (CDPH) “Never Event”, and/or Joint Commission Sentinel Event. (See Appendix A for a complete list of CDPH reportable events).

NEAR MISSES

A near miss is an incident or unsafe condition with the potential for injury or damage. A near miss may also be considered a “close call”. Near misses are much more common than actual errors, in some studies up to 300 times more common.

A near miss can involve actions related to medication, medical treatment, medical devices, visitors, or employees. For example, an incorrect medication that was drawn up but not given would be considered a near miss.

It is extremely important for workforce members to report not only errors, but near misses as well because of their frequency. Reporting of near misses allows your facility to collect data and determine priorities for patient safety activities. Near miss data also provides an opportunity to identify weaknesses in the healthcare system and, most importantly, design systems that can prevent adverse events.

A near miss should be reported in the same fashion that an error would be reported at your facility through the online PSN.

LACDHS Policies 311.0-311.3 require that events be reported immediately to your chain of command. You can do this by completing an event report using the online PSN system.

All witnesses or individuals responding to an event or near miss are expected to complete an event report using the PSN or back-up system, whenever any of the following occur:

- An unexpected adverse outcome, whether or not the treatment has been proper or improper;
- A patient or family member is upset with the care or treatment provided;
- A patient suffers an injury as the result of either a medical device or a pharmaceutical agent;
- A patient or visitor sustains an injury;
- A therapeutic mishap; or,
- A Critical Clinical Event, “Never Event”, and/or Joint Commission Sentinel Event.

If in doubt, fill one out.

When reporting either an event or near miss through the PSN system or a back-up method, all mandatory fields must be completed. Workforce members are encouraged to add additional specific details including the names of all parties involved and all known details that are not mentioned in the patient’s chart. The reports should be objective, factual, and thorough. PSN reports will automatically be routed to appropriate people for follow-up once submitted. If using a back-up method for reporting, follow your facility’s procedure.

Event notifications cannot be used in litigation against the County as long as certain protections are in place to maintain confidentiality. These include the following:

- Do not attempt to print out reports from the PSN system unless authorized to do so
- Do not mention or place a copy of the report in the patient's medical record
- Do not make copies of the report
- If using a back-up method, route the written report according to your facility's procedure within 24 hours.

In addition to completing an event notification, events may also be reported verbally. Calls can be made to your facility's Risk Management Department or to the County's third party administrator (TPA). The third party administrator manages all professional liability claims for the County of Los Angeles and maintains a 24-hour reporting hotline; (562) 492-1859. Although the TPA administers claims for your facility, they should not be consulted for legal advice or be used to replace reporting via the PSN.

Any workforce member who has concerns about the safety or quality of care provided in the health care setting may report these concerns to the LACDHS Patient Safety Hotline at (213) 989-SAFE (7233) or by email at patientsafety@dhs.lacounty.gov. Workforce members may also report concerns directly to the Joint Commission via the internet at www.jointcommission.org or by phone at (800) 994-6610. Workforce members will not be punished or retaliated against for reporting adverse events, errors, close calls, or safety or quality concerns.

Reporting Safety or Quality of Care Concerns

In addition to reporting concerns through your supervisor or manager, there are several external mechanisms for reporting concerns:

- LACDHS Patient Safety Hotline: (213) 989-7233 or patientsafety@dhs.lacounty.gov
- The Joint Commission www.jointcommission.org or (800) 994-6610

Managing the Event

When an unusual event occurs, it is important to manage that event properly. The following actions should be taken to prevent further complications:

- Provide any immediate care needed by the patient.
- Designate a trained spokesperson from the treating team to keep the patient/family member informed.
- Consult with your facility's Risk Manager for advice/coordination in disclosing the event with the patient or family.
- Save any "evidence", such as medical device packaging, equipment, photographs taken at the time, x-ray films, fetal monitoring strips, EKG strips, staffing sheets, and patient census logs. Deliver them to the Risk Manager or your supervisor within 24 hours of the event.
- Report the event immediately via the PSN or back-up method.
- Document facts about the event clearly and objectively in the medical record, including conversations with the patient and family. Consult with the Risk Manager or supervisor if unsure of what or how to document. Do not document discussions with the Risk Manager in the patient's chart.

- Do not discuss the event with anyone outside of the facility unless authorized to do so by the Risk Manager.
- Maintain confidentiality of the workforce member and patient(s) involved in the event, and any resulting investigative findings.

Disclosure of unanticipated outcomes is required by the Joint Commission and should be taken very seriously. Your facility's Risk Manager can guide you in timely and appropriate communication with the patient about the event. For additional information about communication of unanticipated outcomes, see the LACDHS Policy "Communication of Unanticipated Outcomes" # 311.201.

Risk Avoidance Tips

Although risk and ensuing litigation can never be completely avoided, there are some ways to limit exposure. The following section describes some simple measures that can be taken to reduce the risks of litigation.

COMMUNICATION TIPS

Studies have shown that most of the lay public does not understand the details of providing medical care. They do, however, have some ideas about how that care should be given. Most would like information about their particular condition and treatment in a manner that they can understand. Communicating this information to your patients is one of your most important roles.

Patients judge a health care practitioner's competency by their ability to be compassionate and caring. Studies have shown that many healthcare providers are sued by their patients not because of their level of technical skill, but because of their perceived attitude toward the patient. It is important, therefore, to maintain a caring and compassionate attitude, to treat patients with dignity, and to answer their questions in language they understand while empowering them to participate in their care.

PATIENT CONFIDENTIALITY

When discussing information about a particular patient, be aware of who is around you. Many lawsuits have arisen from casual conversations about a particular patient that has been overheard by a friend, relative, or co-worker. Consider also that when speaking with patients or family, other people may be around (like someone in the next bed, hallway, or lunch room) who may overhear your conversations. Be aware of what you say and who may hear it. Sensitive information (like HIV results) must be relayed in private.

In 1996 the Federal Government established a law, the Health Insurance Portability and Accountability Act (HIPAA) which requires healthcare providers to implement certain administrative, physical and technical safeguards to ensure the confidentiality and integrity of electronic protected health information (PHI). Unauthorized access, use, and/or disclosure of PHI, or the failure to maintain and safeguard PHI may lead to disciplinary action and fines. Workforce members are expected to comply with these regulations by performing simple actions such as logging off computers when finished. See the LACDHS Policies #361.1-361.9 for additional information about ensuring confidentiality with PHI.

The Medical Record

The patient's medical record is a legal document belonging to the County of Los Angeles. The primary purpose of the medical record is to communicate to other members of the health care team the patient's health care needs and the patient's response as those needs are met. A complete and accurate medical record also: 1) ensures that the healthcare facility complies with accreditation and licensure standards; 2) prevents payers from refusing to pay claims based on poor record keeping; and 3) prevents the assumption of liability in malpractice cases on the basis that the record is missing key documentation.

ACCESS TO THE MEDICAL RECORD

Patients have the legal right to view the information contained within their medical record. With the appropriate authorization, patients may also obtain a copy of the medical record. The only persons authorized to examine a patient's medical record are, with few exceptions, the patient and the health care team responsible for the care of the patient. Friends, family members, and others are prohibited access to a patient's medical record unless specifically authorized by the patient. If you have questions regarding requests to view or obtain information from the medical record, contact your supervisor, Risk Manager, or Medical Records Department.

MEDICAL RECORD DOCUMENTATION

Because the medical record is a legal document, it is important to ensure completeness and integrity. The medical record reflects a recording of factual, assessments pertinent to the patient. The medical record is not an appropriate place to document frustration with other health care team members or to speculate as to someone else's involvement in a particular event. Inaccurate, incomplete, illegible or altered medical records reflect negatively on the writer's credibility.

As a general rule, medical records should follow the guidelines below:

- Dates, times, signatures and titles are required at the time each entry is made. Additionally, late entries (notes that are recorded out of time sequence with existing notes) must be designated as a "late entry".
- Signatures must be legible, or the name shall be printed below the signature.
- Authorized users of signature stamps or computer keys may not share their stamp or key.
- Each page shall include identifying information including, at least, patient's full name, date of birth (if known), gender and medical record number.
- Providers must review previous notes by other providers at the time of documenting progress note to ensure continuity and consistency in the record.
- Correction to the medical record entries shall be made so that the original entry remains readable (i.e. by drawing one line through the entry) and the correction dated, timed and initialed. Also, notes recorded to clarify previously written information must make reference to the prior note being clarified.

Notes written by residents and interns must reflect attending supervision. Residents and interns should document "discussed with attending or chief resident" to demonstrate supervision. In some cases notes must be co-signed by the attending or chief resident. (See Appendix B for LACDHS Resident Supervision Guidelines.)

FALSIFICATION OF MEDICAL RECORDS

Mistakes made during documentation are inevitable, but the criteria and methods for correcting mistakes and omissions in medical records are explicit. Making entries that are untruthful or intended to conceal the truth are considered to be falsification of the medical record. Falsification of the medical record includes:

- Altering previous entries with the intent to obliterate the original documentation.
- Knowingly destroying any part of the medical record and replacing it with a new record designed to reconstruct facts or events.
- Knowingly or intentionally documenting information known to be false.
- Documenting care provided before it has been provided (pre-charting).
- Re-creating notes without properly identifying the date and time they were actually written.

If a prior record entry must be changed, line out the incorrect data with a single line in ink, leaving the original writing legible. The correction should be dated, timed and initialed. The correction note should give reference to the prior note being clarified.

DOCUMENTING TELEPHONE CONVERSATIONS

Communication over the phone is an important part of the patient's care. Documentation of conversations with a patient must include the date and time of the call, the name of the person who initiated the call, the nature of the complaint or reason for the call, advice or follow-up instructions given, and the signature of the person giving advice. Be sure to follow your facility's policies regarding giving advice over the phone.

Consent

When patients come to the hospital or health center, they retain their right to choose what is done to their body. Before any medical procedure or treatment is performed, the patient, or legally authorized representative, must provide consent for that procedure or treatment. This consent may be either implied (such as holding one's arm out for a blood draw) or expressed either by written or verbal means. Failure to obtain proper consent for treatment may result in a claim of battery or professional negligence. Battery may also arise if the patient consents to particular procedure and the provider either exceeds the scope of the consent, or performs a different procedure than what the patient consented to.

INFORMED CONSENT

If the treatment proposed is complex, the consent must be "informed". This requires the treating physician to address the following elements of informed consent:

- the nature of the proposed care, treatment, services, medications, interventions, or procedures
- potential benefits, risks, or side effects, including potential problems that might occur during recuperation
- the likelihood of achieving goals
- reasonable alternatives to the treatment and relative risks, benefits and side effects related to alternatives, including the possible result of not receiving care, treatment and services
- any potentially conflicting interests, such as research or financial interests
- when indicated, any limitations on the confidentiality of information learned from or about the patient

It is the treating physician's responsibility to obtain informed consent.

Although nurses and other healthcare providers may assist in the process, it is the treating physician who must discuss all of the above elements and obtain the informed consent in terms a lay person can understand.

The iMed informed consent program and associated printed form, shall be used whenever informed consent is required. The physician obtaining the patient's informed consent shall also document in the medical record that a discussion was held with the patient or his/her legal representative; the patient or his/her legal representative fully understood the nature of the procedure, including the risk and benefits of agreeing or refusing the procedure; and that informed consent was obtained.

The form itself is not informed consent; it is evidence that informed consent was obtained. The form is not a substitute for the critical role of the physician in the informed consent process.

WHO MAY CONSENT

The determination of who may consent to medical treatment is based on the patient's legal status, capacity to make decisions, and the physician's assessment of the patient. Capacity means a person's ability to understand the nature and consequences of a decision, and includes, in the case of proposed health care, the ability to understand its significant benefits, risks, and alternatives. Those able to give consent include, but are not limited to:

- Adults (over age 18) with capacity
- Appointed agents or surrogates
- Emancipated and/or self-sufficient minors
- Minors in certain situations (conditions relating to pregnancy, family planning, treatment of sexually transmitted diseases, drug or alcohol treatment, and mental health care)
- Parents or legal guardians of a minor
- Closest available relative

If the patient or legally authorized representative has the capacity to make an informed decision, but is physically unable to write his or her name, the person's mark must be obtained. This is done by the physician first writing the person's name in full and then having the person place an "X" beneath it. Two people must witness the signer place his or her mark on the consent form.

Obtaining consent for treatment on patients that lack the capacity to make informed decisions or refusal on medical care may require a court order, according to California Probate Code 3200. Since there are many exceptions to the consent laws relating to minors and incapacitated patients, consult your Risk Manager if you are unsure of who may consent.

EMERGENCY SITUATIONS

In the situation of a medical emergency, treatment may be given if the situation meets the criteria for an emergency, and if there is no evidence to indicate that the patient (or their legally authorized representative) would refuse the treatment. California law defines a medical emergency to exist when:

- immediate services are required for the alleviation of pain; or
- immediate diagnosis and treatment of unforeseeable medical conditions are required, if such conditions would lead to serious disability or death if not immediately diagnosed and treated.

The exception for obtaining consent in medical emergencies applies to minors as well as to adult patients. However, it is important to note that only the emergency condition may be treated and any treatment beyond that may not be administered without proper consent.

TELEPHONE CONSENT

Consent should be obtained by telephone only if the person having the legal ability to consent the patient is not otherwise available. If telephone consent is used, the physician must provide the patient's legal representative with all of the information the physician would disclose if the person were present. The iMed form shall also be used during telephone consent. The telephone discussion should be witnessed by a second authorized workforce member and noted on the iMed form.

USE OF AN INTERPRETER

If a healthcare provider cannot communicate with the patient because of language or communication barriers, an interpreter must be provided. "Interpreter" means someone fluent in English and in the necessary second language, who can accurately speak, read, and readily interpret the necessary second language. An Interpreter Attestation Form must be completed anytime an interpreter is required to translate the discussion between a patient (or legally authorized representative), and a physician for the purpose of obtaining an informed consent and/or the oral interpretation of information contained on the informed consent form.

A designated bilingual employee or staff interpreter, contracted interpreter, designated bilingual volunteer, or telephone interpreter service is required to translate the medical information or informed consent. If a patient insists on choosing a non-facility affiliated interpreter, family member or a friend to translate the required medical information and informed consent, the medical record must document that there was an offer of a facility affiliated interpreter which was rejected, stating the reason and the name of the person serving as interpreter. This interpreter will also be required to sign the Interpreter Attestation Form. Under no circumstances may a minor, younger than eighteen years of age, be recruited to interpret during this process.

REFUSAL OF TREATMENT

Patients have a constitutional right to decide and consent to which treatments and procedures are performed on their body. This includes the right to refuse treatment as well.

When a patient refuses drugs, blood, or other medical treatment ordered, the physician must determine if the patient has the legal authority and competence to refuse such treatment. If the patient is determined to be competent, the physician

must ensure that the patient is aware of the possible risks and complications that may occur as a result of refusal. The physician has a duty to give the patient all of the information that is relevant to a meaningful decision to refuse.

The refusal of treatment should be clearly documented in the patient's medical record by including a summary of the events that led to the refusal, and the outcome of the discussion between the patient and the physician.

Other Risk Management Issues

Your Risk Management Department also provides oversight and guidance as it relates to laws and regulatory policies that impact the provision of healthcare. Some of the laws or policies affecting your practice include the following topics.

ADVANCED DIRECTIVE

In 1991, Congress passed the Patient Self-Determination Act (PSDA). This act requires all hospitals, skilled nursing facilities, and home health agencies to maintain policies and procedures assuring that adults receiving medical care are provided written information at the time of admission concerning their right to make decisions regarding medical care. This includes the right to formulate advance directives.

An advance directive is a written document that may authorize another person to make healthcare decisions for a patient when the patient is no longer able to make their own decisions. The advance directive may contain information about a patient's desires, particularly as it relates to end-of-life care. A patient may also designate another person to make healthcare decisions even if the patient is still capable of making their own decisions.

DO NOT RESUSCITATE ORDER

A do not resuscitate (DNR) order is one which directs healthcare providers not to initiate resuscitative measures in the event of cardiac or respiratory arrest. A DNR order authorizes the withholding of life-sustaining procedures. It does not authorize the withdrawal of procedures that have previously been initiated. Failure to follow a DNR order may lead to a claim of battery against a healthcare provider.

THE PAUL GANN ACT

In 1991, Section 1645 of the California Health and Safety Code was amended to include a requirement that whenever there is a reasonable possibility that a blood transfusion may be necessary, the physician shall inform the patient of the positive and negative aspects of receiving either autologous blood (coming from the patient) or allogeneic blood (coming from a donor).

This information must be communicated to the patient through a standard written summary developed by, or based on, the California Department of Public Health's publication "A Patient's Guide to Blood Transfusion". The written summary does not replace the informed consent process which must occur prior to blood or blood product administration. The Paul Gann Safety Act also requires that, when there are no life-threatening emergency or medical contraindications, the physician shall allow adequate time prior to the procedure requiring blood donation, for pre-donation of autologous blood to occur. The patient's receipt of the written summary of blood transfusion and informed consent must be documented in the patient's chart.

WORKPLACE VIOLENCE

All workforce members, whether full-time, part-time, or contracted, are entitled to a safe work environment. To help protect workers from violence, LACDHS developed a “zero tolerance” policy (LACDHS Policy #792). Threats, threatening behavior or acts of violence against workforce members, patients, visitors or other individuals by anyone on County property or anywhere a workforce member is engaged in County-related business, are prohibited. Any workforce member receiving a threat or injury as a result of a violent episode must report the occurrence immediately to the facility’s Safety Police and file an event notification on the PSN.

REPORTING ABUSE

The California Welfare and Institutions Code requires all LACDHS healthcare providers to report any known or suspected instances of abuse to protective agencies immediately. Abuse must be reported for all cases involving children, domestic partners, and dependent adults to County Police and Social Services. Penalties for not complying with these regulations may include possible jail time and or monetary fines.

EMTALA

In 1986, the Emergency Medical Treatment and Active Labor Act (EMTALA), was passed by Congress as a part of the Consolidated Omnibus Reconciliation Act (COBRA). The purpose of the legislation was to address the problem of hospitals refusing to care for patients or transferring them to other facilities based on their ability to pay.

Any patient on County premises that asks for emergency or labor related treatment must receive a medical screening exam and any emergency condition must be stabilized to the best of the facility’s ability prior to transfer to another facility. Questions regarding EMTALA can be addressed by your Risk Manager or QIPS at patientsafety@dhs.lacounty.gov.

Medical-Legal Information

Being involved in a negligence or medical malpractice lawsuit can be frustrating and confusing. Understanding a few legal concepts, if ever confronted with this situation, may make the process easier.

INDEMNIFICATION

As public employees of the County of Los Angeles, indemnification (legal protection) is provided for any injury arising as a result of the employee’s action or omission occurring within the scope of employment under Government Code 825. For purposes of this code the word “employee” includes officers, employees, servants and volunteers but excludes “independent contractors”. Independent contractors should consult their individual contracts for the terms regarding indemnification while working for LACDHS.

Employees and covered contractors of Los Angeles County are not protected from liability resulting from:

- willful misconduct, corruption, malice, or lack of good faith;
- fraudulent activity;

- intentional infliction of an injury, or;
- any act performed outside the course and scope of employment

Los Angeles County is considered to be self-insured. Essentially this means that the County does not have insurance and all costs related to litigation are ultimately borne by Los Angeles County taxpayers.

ELEMENTS OF NEGLIGENCE

Negligence is failing to do something that a reasonably prudent person would have done under similar circumstances. Medical-malpractice is a form of negligence where the act is committed in the course of a professional responsibility. With an allegation of medical malpractice, the plaintiff must establish and prove all of the following elements:

1. That a duty was owed to the plaintiff;
2. That the health care provider breached that duty;
3. That breaching their duty proximately caused an injury; and
4. That the plaintiff suffered damages relative to the injury.

DUTY

Duty begins when you enter into a relationship with a patient to provide care. In performing your duty, you must provide a reasonable level of care, similar to what others practicing in your field would provide under the same circumstances. If the standard of care is not met, then a breach of duty is said to exist.

BREACH OF DUTY

In a malpractice action the breach of duty must have proximately caused an injury. This means that had the practitioner acted, or not acted in the manner alleged, the injury would not have occurred. Proximate cause attempts to establish a direct cause and effect between the practitioner's conduct, or lack thereof, and the patient's injury.

DAMAGES

Damages are the losses the patient/plaintiff suffered as a result of the injury. They can be economic, emotional, related to future potential, or personal. These are the monetary awards levied on the defense to "pay" for the injury.

THE LEGAL PROCESS

Throughout the legal process and the steps involved, workforce members are expected to cooperate with the county counsel or other attorneys approved by the county counsel. As part of the county indemnification rules, employees are provided legal counsel free of charge when they are being represented for a claim arising from actions made in the scope of their employment. Using County funds to pay a private attorney for legal representation is prohibited. County counsel (or county counsel designee) may attend hearings and trials, assist in making settlements, and secure or provide evidence on the employee's behalf. Employees should not voluntarily make any payment, assume any obligation, or incur any expense related to claims against the county (County Code: Ord. 9022 § 1 (part), 1966: Ord. 8345 § 1 (part), 1963: Ord. 7552 § 1 (part), 1959: Ord. 4099 Art. 3-D § 93.88, 1942.) Employees are expected to participate in the defense of the alleged claim as noncooperation may result in disciplinary action.

When a person begins a legal action against the county, there are certain steps that must be followed. The first step involves the plaintiff serving a summons and complaint which outlines the alleged action against you. Should you ever personally receive one of these items, or any other legal document related to a claim against you as part of your County employment, immediately forward the documents to your Risk Manager for appropriate handling and response.

If you receive a summons or complaint regarding care provided by you, immediately notify your Risk Manager

INTERROGATORIES

As part of the legal process, each side is allowed to ask and receive responses to written questions from the opposing party. These questions are called interrogatories, and are prepared by attorneys on their respective sides. Generally, they are not sent directly to you, but to your defense attorney. However, if you receive an interrogatory, notify your facility Risk Manager. Do not communicate or correspond with any attorney unless specifically authorized to do so by your facility Risk Manager.

DEPOSITIONS AND TESTIMONY

The deposition process is a means whereby you provide your testimony under oath. This testimony may later be used at trial to impeach, or contradict you. Therefore, it is important that you prepare for your deposition, meet with the defense counsel provided, and follow their instructions.

County code and conflict of interest policies restrict the type of depositions or testimony that employees may take part in. Specifically, employees are not allowed to provide expert testimony against the County in any legal action where the County is a party to the action. Employees are allowed, and expected to, provide testimony in proceedings for defense of the County. Any employee who is required to testify in any judicial proceeding in their official capacity, shall be entitled to collect their usual salary.

TRIAL VERSUS SETTLEMENT

Some cases will be taken to trial and others will be settled. The decision to act either way will be made by County Counsel with the County's and your interest in mind. Should County Counsel advise you to agree to a settlement, and you refuse (without a good and sufficient reason to do so) the county is not liable for any resulting judgments against you. Your facility Risk Manager can provide you with information regarding the status of cases if you are personally involved.

LICENSEE REPORTING TO LICENSING BOARD

Pursuant to the laws that govern mandatory malpractice reporting to licensee boards (i.e. Medical Board, Nursing Board), LACDHS is required to report licensees to their respective board when they are involved in malpractice cases above certain dollar amounts. The amount of money apportioned to the licensee, not necessarily the total amount of money awarded, determines when a licensee will be reported. Each licensing Board has determined their reportable limits for their licensees. To view the current reportable limits and obtain additional information about mandatory reporting of licensees, review the LACDHS Policy #311.3, "Licensee Reporting to Licensing Board" in Appendix C.

CONCLUSION

QIPS hopes you find this booklet useful during your employment with LACDHS. It is meant to serve as a guide and resource when navigating the legal complexities of healthcare. The scope of this handbook is limited, and all of the legal topics in healthcare exceed well beyond its covers. Should you have questions that are not answered in this booklet, please contact your Risk Manager or QIPS at patientsafety@dhs.lacounty.gov.

APPENDIX A



Health Services
LOS ANGELES COUNTY

POLICIES AND PROCEDURES

SUBJECT: ADVERSE EVENT REPORTING

POLICY NO: 311.202

PURPOSE:

To comply with the mandated reporting requirements of Health and Safety Code § 1279.1(b) and to support the improvement of patient safety and quality improvement initiatives.

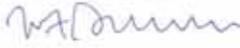
SCOPE:

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

POLICY:

All DHS health care facilities shall report adverse events that are urgent or emergent threats to the welfare, health, or safety of patient, personnel, or visitors to the DHS Chief Medical Officer, the Chief Network Officer, or to the DHS Director via phone or e-mail not later than twenty-four (24) hours after the adverse event has been detected. For after-hours phone numbers, please consult the Director's Staff Roster. Facilities shall report all other adverse events within 5 days to the Director, Quality Improvement and Patient Safety. It is our policy to investigate the source of the event and initiate any mitigation actions that may be indicated. Investigations are to be completed according to the attached "Procedures for Compliance with Los Angeles County Ordinance 2.76.590 Risk Management Protocol – Quality Improvement Program. Facilities shall also report all adverse events using the Patient Safety Net (PSN). Reportable non-clinical events must be reported in accordance with DHS Policy No. 311, "Incidents Involving Potential Claims Against the County."

Acute care hospitals are also required to report an adverse event, as defined within Health and Safety Code §1279.1, to the California Department of Public Health (CDPH) no longer than 5 days after the event has been detected; or, if the event is an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors, not later than twenty-four (24) hours after the adverse event has been detected. The report shall be completed using the "DHS Reporting Form – Adverse Events" (attached) and will include a brief narrative describing the event and a facility identification number. The report shall be sent concurrently to CDPH and to the DHS Director, Quality Improvement and Patient Safety. To send the report to the DHS Director, e-mail it as a PDF file or fax it to 213-250-5136. Please include a patient file number and PSN number in QIPS' copy.

APPROVED BY: 
REVIEW DATES:

EFFECTIVE DATE: September 1, 2010
SUPERSEDES: January 1, 2008 and
DHS Policy 311.2 dated 7/1/98, 9/1/09

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SUBJECT: ADVERSE EVENT REPORTING

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It is also our policy to cooperate fully with the CDPH throughout the process.

If the facility is uncertain whether an event should be reported to CDPH, the DHS Chief Medical Officer, the Chief Network Officer, or the DHS Director shall be contacted by phone and the decision to report or not to report to CDPH will be made jointly between the facility and Health Services Administration. If after discussion with Health Services Administration there is still uncertainty about reporting, the facility's General Counsel may be consulted. For after-hours consultation with the DHS Chief Medical Officer, DHS Chief Network Officer, DHS Director and General Counsel, consult the Director's Staff Roster for contact information.

DEFINITIONS:

"Adverse event" includes *any* of the following:

1. Surgery performed on a wrong body part that is inconsistent with the documented informed consent for that patient. A reportable event does not include a situation requiring prompt action that occurs in the course of surgery or a situation that is so urgent as to preclude obtaining informed consent.
2. Surgery performed on the wrong patient.
3. The wrong surgical procedure performed on a patient that is inconsistent with the documented informed consent for that patient. A reportable event does not include a situation requiring prompt action that occurs in the course of surgery, or a situation that is so urgent as to preclude the obtaining of informed consent.
4. Retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained.
5. Death during or up to 24 hours after induction of anesthesia after surgery of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.
6. Patient death or serious disability associated with the use of a contaminated drug, device, or biologic provided by the health facility when the contamination is the result of generally detectable contaminants in the drug, device, or biologic, regardless of the source of the contamination or the product. (See also DHS Policy No. 311.1)
7. Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. For purposes of this subparagraph, "device" includes, but is not limited to, a catheter, drain, or other specialized tube, infusion pump, or ventilator. (See also DHS Policy No. 311.1)

EFFECTIVE DATE: September 1, 2010

SUPERSEDES: January 1, 2008 and DHS Policy
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8. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.
 9. An infant discharged to the wrong person.
 10. Patient death or serious disability associated with patient disappearance for more than four hours, excluding events involving adults who have competency or decision-making capacity.
 11. A patient suicide or attempted suicide resulting in serious disability due to patient actions after admission, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the health facility.
 12. A patient death or serious disability associated with a medication error, including, but not limited to, an error involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose.
 13. A patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products.
 14. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy, including events that occur within 42 days post-delivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy.
 15. Patient death or serious disability directly related to hypoglycemia, the onset of which occurs while the patient is being cared for in a health facility.
 16. Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life.
"Hyperbilirubinemia" means bilirubin levels greater than 30 milligrams per deciliter.
 17. A Stage 3 or 4 ulcer, acquired after admission, excluding progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admission.
 18. A patient death or serious disability due to spinal manipulative therapy performed at the health facility.
 19. A patient death or serious disability associated with an electric shock while being cared for in a health facility, excluding events involving planned treatments, such as electric countershock. (See also DHS Policy No. 311.1)
 20. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by a toxic substance.
 21. A patient death or serious disability associated with a burn incurred from any source while being cared for in a health facility.
 22. A patient death associated with a fall. (See also DHS Policy No. 920)
-

EFFECTIVE DATE: September 1, 2010

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23. A patient death or serious disability associated with the use of restraints or bedrails.
24. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider.
25. The abduction of a patient of any age.
26. The sexual assault on a patient within or on the grounds of the facility.
27. The death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds.
28. An adverse event or series of adverse events that cause the death or serious disability of a patient, personnel, or visitor. (See also DHS Policy No. 920)

"Serious disability" means a physical or mental impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function, if the impairment or loss lasts more than 7 days or is still present at the time of discharge from an inpatient health care facility, or the loss of a body part.

"Sentinel event" is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

Such events are called "sentinel" because they signal the need for immediate investigation and response.

The terms "sentinel event" and "medical error" are not synonymous; not all sentinel events occur because of an error and not all errors result in sentinel events.

DISCLOSURE

The patient, or the party responsible for the patient, will be notified of the nature of the adverse event by the time the report to the DHS/CDPH is made. Such disclosure shall be reflected in the patient's record. The patient or the party responsible for the patient shall **not** be provided with a copy of the PSN/DHS/CDPH report. These reports will not be placed in the medical record. (See also DHS Policy No. 311.201)

INVESTIGATION

An investigation into the cause of the event shall be undertaken, using root cause analysis, intensified review or other approved investigative process. The investigation shall be

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SUPERSEDES: January 1, 2008 and DHS Policy 311.2 dated 7/1/98, 9/1/09

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conducted according to the *Procedures for Compliance with Los Angeles County Ordinance 2.76.590 Risk Management Protocol – Quality Improvement Program*. The investigation will be conducted for the purpose of the evaluation and improvement of the quality of care in the hospital.

REFERENCES:

Health and Safety Code §1279.1(b)
Los Angeles County Ordinance §2.76.590
Joint Commission policies and procedures

DHS Policies

- 311 Incidents Involving Potential Claims Against the County
- 311.1 Medical Device Reporting Program
- 311.201 Communication of Unanticipated Outcomes
- 311.203 Reportable Non-Clinical Events
- 920 Accident/Injury Reporting

Procedures for Compliance with Los Angeles County Ordinance 2.76.590 Risk Management Protocol – Quality Improvement Program

EFFECTIVE DATE: September 1, 2010

SUPERSEDES: January 1, 2008 and DHS Policy
311.2 dated 7/1/98, 9/1/09

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APPENDIX B

DEPARTMENT OF HEALTH SERVICES



COUNTY OF LOS ANGELES

SUBJECT: DHS POLICY ON SUPERVISION OF RESIDENTS

POLICY NO. 310.2

LOS ANGELES COUNTY-DEPARTMENT OF HEALTH SERVICES

- 1. Introduction
 - 1.1 Purpose. This policy on supervision of resident physicians is established to promote patient safety, enhance quality of patient care, and improve post-graduate education consistent with the Accreditation Council for Graduate Medical Education (ACGME) requirements. These requirements include, but are not limited to: "Supervision: There must be sufficient institutional oversight to assure that residents are appropriately supervised. Residents must be supervised by teaching staff in such a way that the residents assume progressively increasing responsibility according to their level of education, ability and experience. On-call schedules for teaching staff must be structured to ensure that supervision is readily available to residents on duty. The level of responsibility accorded to each resident must be determined by the teaching staff." (ACGME)
 - 1.2 Scope. This policy applies to any care rendered by a resident in a facility operated by the Los Angeles County Department of Health Services.
 - 1.3 Approval: The Department of Health Services has established this policy.
 - 1.4 Review: The Department of Health Services Medical Directors' Committee shall review this policy as often as necessary, but no less than every three years.
- 2. Definitions
 - 2.1 "Attending": a member of the organized medical staff with specific privileges to perform invasive or operative procedures, deliveries, or other specific activities over which they supervise.
 - 2.2 "Resident": all physicians, dentists, podiatrists, (interns and residents) enrolled in a residency training program.
 - 2.3 "Supervisory resident": a resident designated to perform specific functions in patient care (i.e. specific operative procedures, deliveries or defined patient care activities) without direct attending supervision and may supervise a non-supervisory resident to perform the specifically designated procedures as determined by each program.
 - 2.4 "Non-supervisory resident" : a resident who may not perform, without appropriate supervision, invasive or operative procedures, deliveries, or other specific activities.
 - 2.5 "Specific privileges": the authorization to perform invasive or operative procedures, deliveries, or other specific activities which have been granted by the medical staff.
 - 2.6 "Disposition" means discharge of a patient from the hospital or from a unit therein, or from a clinic location.
- 3. General Coverage
 - 3.1 The supervisory lines of responsibility for care of patients must incorporate, at minimum, the following:

EFFECTIVE DATE: 2/20/97

REVISED AND CODIFIED: 11/6/00

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APPROVED:

- 3.1.1 An attending physician shall be available by phone to resident physicians 24-hours per day.
- 3.1.2 In those instances where the attending physician's responsibility has been delegated to a supervisory resident, these supervisory residents shall be present and available to resident physicians 24 hours per day.
- 3.1.3 For resident physicians in training programs where required by the ACGME, an attending physician shall be available in-house 24 hours per day.
- 3.1.4 For ambulatory/non-urgent care, an attending physician or supervisory resident shall be available on-site at the facility during hours of operation as consistent with respective ACGME/RRC requirements (see section 3.2 and 3.3 below)
- 3.2 Each residency/training program shall establish policies on the supervision of residents through explicit written descriptions of supervisory lines of responsibility for care of patients. Such guidelines must be communicated to all members of the program's teaching staff and residents.
 - 3.2.1 These supervisory lines of responsibility for patient care shall take into account the safety and well being of patients and their rights to quality care.
 - 3.2.2 When a supervisory resident is included in the supervisory lines of responsibility for care of patients, attending physicians remain fully accountable for supervision of all residents.
- 3.3. Supervision of Residents: Although patient care is provided by residents, ultimate responsibility for patient care and supervision of residents rests with the attending physician.
 - 3.3.1 Each department's policy on supervisory lines of responsibility of attending physicians' supervision of residents shall define:
 - 3.3.1.1 the specific procedures, consultations or services that require direct attending physician supervision, and
 - 3.3.1.2 the specific procedures, consultations or services for which supervision by supervisory residents is appropriate.
 - 3.3.1.3 the extent of attending physician or supervisory resident presence required to adequately supervise procedures, consultations or services.
 - 3.3.1.4 the responsible attending physician by service or function
 - 3.3.1.5 a process and procedure for designating a supervisory resident including a specific minimum of operative procedures, deliveries, and other patient care activities supervised by attending physicians, developed by the relevant program and approved by the facility Medical Executive Committee;
- 3.4 No resident shall be designated as a supervisory resident for a given procedure, consultation or service unless all of the following conditions are met:
 - 3.4.1 documentation that the resident has demonstrated satisfactory judgement and competence in the application and performance of the procedure(s), consultation or service;
 - 3.4.2 demonstration of satisfactory performance of a specific minimum number of operative procedures, deliveries, or other defined patient care activities under direct supervision, including a specific minimum number under the direct supervision of an attending physician;

- 3.4.3 recommendation by the program director and/or service chief to designate a resident as a supervisory resident for the specific operative procedure(s), deliveries or defined patient care activities;
- 3.4.4 review and approval by the department chairman.
- 4. Invasive and Operative Procedures and Deliveries
 - 4.1 An attending physician or supervisory resident shall see and evaluate each patient prior to any operative procedure or delivery and shall document this evaluation in the medical record.
 - 4.2 An attending physician is responsible to assure the execution of an appropriate informed consent for procedures and deliveries with consent form and progress note documenting the consent discussion in the medical record.
 - 4.3 An attending physician is responsible to assure appropriate supervision of residents during all operative or invasive procedures.
 - 4.4 An attending physician or supervisory resident shall be present with the patient for all operative or invasive procedures.
 - 4.4.1 If the attending is present for the operative or invasive procedure or delivery, he/she must document in the medical record that he/she has evaluated the patient and authorizes the procedure.
 - 4.4.2 If the attending physician is not present (see section 3.3) for the operative or invasive procedure or delivery, the supervisory resident must document in the medical record that he/she has discussed the case with the attending and the attending authorizes the resident to proceed.
 - 4.5 An attending physician must assure an operative or procedure note is written or dictated within 24 hours of the procedure and shall sign the record of operation ("green sheet") in all situations for which direct attending physician supervision is required.
- 5. Emergency Department/Urgent Care
 - 5.1 An attending physician is responsible for supervision of the resident and appropriate evaluation of the patient for each emergency department visit.
 - 5.2 An attending physician or supervisory resident physician shall review and sign the patient's record prior to disposition.
- 6. Ambulatory/non-urgent care
 - 6.1 For each new patient, an attending physician shall supervise the resident's evaluation of the patient and shall co-sign the resident physician's note prior to disposition, as required by policy established under section 3.3.
 - 6.2 For follow up visits, an attending physician or supervisory resident shall co-sign the resident physician's note prior to disposition or the resident physician shall document that the attending physician concurs with the assessment and management (see section 3.3).
- 7. Inpatient admissions
 - 7.1 An attending physician shall see and evaluate each inpatient within 24 hours of admission and shall co-sign the resident's admission note or record his/her own admission note.
 - 7.2 An attending physician shall see and evaluate the patient at least every 48 hours and shall ensure that the resident includes in the progress note that he/she has discussed the case with the attending or the attending physician shall record his/her own note.

- 7.3 An attending physician shall discuss the discharge planning with the resident. The resident shall document in the medical record the discussion of the discharge plan and the attending physician concurrence with the discharge plan prior to the patient's discharge or the attending shall record his/her own note.
8. Intensive Care
- 8.1 An attending physician or supervisory resident shall discuss every new patient with the resident physician within 4 hours of admission to the Intensive Care Unit. The resident shall document this discussion with the attending physician.
- 8.2 An attending physician shall see and evaluate the patient within 24 hours after admission to the Intensive Care Unit, discuss this evaluation with the resident and document this evaluation and discussion in the medical record.
- 8.3 The attending physician shall see and evaluate the patient at least daily thereafter and discuss this evaluation with the resident. The attending shall ensure that the resident includes in the progress note that he/she has discussed the case with the attending, or the attending physician shall record his/her own note.
9. Diagnostic/Therapeutic Studies and Procedures
- 9.1 An attending physician shall supervise and document the performance and interpretation of invasive diagnostic/therapeutic procedures in accordance with sections 3 and 4 above.
- 9.2 An attending physician shall review and sign or co-sign the final interpretive reports of diagnostic studies prior to dissemination.
- 9.3 An attending physician or supervisory resident physician shall concurrently supervise a resident physician for an immediate interpretation prior to the written report of diagnostic studies:
- 9.3.1 whenever results are necessary for immediate patient care decisions, or
- 9.3.2 studies are performed on patients in locations such as the Emergency Room or Intensive Care Units, when the clinical service requests immediate interpretation.
- 9.3.3 the immediate interpretation shall be documented in the medical record prior to the written report.
- 9.4 Where diagnostic instruments are used in the evaluation of patients (e.g. ultrasound, Doppler, EKG, among others), an attending physician or supervisory resident shall supervise the resident when such instruments are used to evaluate patients and when the output of such instruments is interpreted.
10. Consultations
- 10.1 The attending physician from the treating service shall assure that in all instances where consultations are requested, they are communicated to the consulting service in a timely manner.
- 10.2 The attending physician from the consulting service shall assure that responses to consultation requests are initiated in a timely manner.
- 10.3 The attending physician from the consulting service shall supervise and document the performance of consultations, in accordance with sections 3 and 4 above.
- 10.4 The attending physician or supervisory resident from the consulting service shall document his/her evaluation of the patient in the medical record.
11. Measurement of performance of residents in patient care.

- 11.1 Each department shall develop a policy and procedure for measurement and documentation of resident performance in patient care sufficient to support a systematic review of the resident's competence to perform the operative procedures, deliveries or other defined patient care activities, for which the resident has been designated as a supervisory resident.
 - 11.2 Each department shall include a systematic review of the resident's activities in patient care as an integral part of the departmental quality assurance process and the information shall be considered in the decisions on reappointment and promotion of each resident.
12. Monitoring
- 12.1. Credentials Committee and Medical Executive Committee will monitor compliance with sections 3.1, 3.2, 3.3, 3.4, 11.1, and 11.2.
 - 12.2 Medical Records Review Committees will include the documentation guidelines set forth in sections 4.1, 4.2, 4.3, 4.4, 4.5, 5.1, 5.2, 5.3, 6.1, 6.2, 7.1, 7.2, 7.3, 8.1, 8.2, 8.3, 9.1, 9.2, 9.3, 9.4, 10.1, 10.2, 10.3, and 10.4 in its review of records.

Revised/final/11/06/00
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APPENDIX C



Health Services
LOS ANGELES COUNTY

POLICIES AND PROCEDURES

SUBJECT: LICENSEE REPORTING TO LICENSING BOARD

POLICY NO: 311.3

PURPOSE:

To establish Department of Health Services (DHS) policy with respect to the reporting of settlements, judgments or arbitration awards as a result of a claim for damages for death or personal injury allegedly caused by a licensee's negligence, error or omission in practice or by the unauthorized rendering of professional services pursuant to Business and Professions Code Sections 801.01 et seq.

To ensure that the full amount of a settlement of a claim for damages for death or personal injury shall not be attributed to a named or alleged licensee when the facts of the case indicate that there are other issues which indicate that the licensee is not fully responsible, systems issues and/or economic reasons in the factors for settlement.

To define the process for reporting individual licensees to licensing boards and apportioning settlement costs to individual licensees.

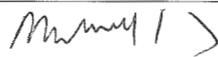
POLICY:

Pursuant to the laws that govern mandatory malpractice reporting to the Medical Board of California (MBC) found in Business and Professions Code Sections 801.01, et seq., the Department of Health Services shall report settlements exceeding reporting thresholds and all judgments or arbitration awards and shall apportion all settlements that are reported to any licensing board.

BACKGROUND:

For medical malpractice claim settlements, judgments or arbitration awards, the Department of Health Services must implement a process for:

1. Reviewing all claims against a licensee to determine reportability;
2. Determining appropriate reporting entity pursuant to Business and Professions Code Sections 801.01 et seq.;

APPROVED BY: 

REVIEW DATES:

EFFECTIVE DATE: October 1, 2011

SUPERSEDES: June 1, 2009

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3. Reporting settlements, judgments or arbitration awards (including licensee information) in accordance with Business and Professions Code Sections 801 et seq. using the following reporting procedure; and
4. Apportioning settlements to prevent the MBC from attributing the full amount of a settlement to each physician reported.

PROCEDURE:

Per Business and Professions Code 801.01, amounts in the settlement agreement, judgment or arbitration award shall be apportioned only among individuals who were "named or alleged" by the plaintiff in either the claim, complaint, discovery, or action or settlement/arbitration or other charging documents by the plaintiff.

The following elements are required in order to establish an allegation: a plaintiff or person on behalf of a plaintiff claims in any of the written forms referenced above that a licensee's negligence, error, omission in practice, or by his or her rendering of unauthorized professional services, caused death or personal injury. A final list of potentially reportable licensees, who were named or alleged by plaintiff, shall be delivered to Health Services Administration Quality Improvement and Patient Safety (HSAQIPS) and the County's Third Party Claims Administrator by defense counsel as a Final Summary in either a separate document prepared by defense counsel or as a section of the final defense counsel evaluation, upon final resolution of the case.

In the case of judgments or arbitration awards, the full amount of the judgment or award attributed to each named licensee will be reported to the appropriate licensing board.

To assist in evaluating claims and lawsuits, County Counsel shall convene a meeting or meetings consisting of appropriate levels of staff and management. If, as a result of these meetings, a decision is made to settle a claim or lawsuit, the facility shall be notified and the reporting procedure, as described below, shall be followed.

Prior to the convening of these meetings Defense Counsel shall identify any named or alleged licensees subject to the reporting requirements under section 801.01 et seq. of the Business and Professions Code in the event that the case is settled. The County's Third Party Claims Administrator shall prepare a letter of notification announcing the date of the meeting and the potential for reporting to the licensing board and shall mail that letter to the potential reportable licensee(s) (Attachment I). For alleged but not named licensees, the documentation that is the basis for the allegation, as the named licensee has already been served, will be provided. The

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licensee(s) who may be subject to reporting in accordance with Business and Professions Code Sections 801.01 et seq. may choose to participate in the meeting. The degree of participation beyond the role of the potential reportable licensee shall be at the discretion of County Counsel. Participation by other peers and/or supervisors may be requested.

In the event that subsequent to the facility meetings, additional licensees are identified by defense counsel as either named or alleged subject to the reporting requirements under section 801.01 et seq. of the Business and Professions Code, defense counsel will notify the County's Third Party Claims Administrator, and additional meeting(s) will be held with all potential reportees invited.

All potentially reportable licensees shall be afforded the opportunity to meet with defense counsel assigned to represent the County and the licensee, prior to the meeting and throughout the process to discuss implications of the reporting requirements and to be appraised and advised of the process and procedures described in this policy. In the event of a conflict between the defense counsel representing the licensee and the County, as determined by County Counsel, a separate defense counsel may be assigned to represent the licensee.

At the meeting(s), the County Counsel will be responsible for all decisions regarding settlement or trial where necessary and, when settlement is decided, the factors for settlement. Attendees will provide input and discuss pertinent aspects of the case. An effort will be made at the meeting to obtain consensus on the decision to settle or go to trial. In addition, if a decision for settlement is determined, an effort will be made to obtain consensus on the factor(s) for settlement. The facility designee shall prepare a letter of notification to potentially reportable licensees not present at the meeting where a decision was made to settle announcing that a decision has been made to settle the case.

If the amount of settlement meets a reporting threshold as described below and there are licensees named or alleged subject to the reporting requirements under section 801.01 et seq. of the Business and Professions Code, then the HSAQIPS Office shall be notified by the County's Third Party Claims Administrator within 24 hours of the settlement decision. In such cases, if the factors for settlement are solely systems and/or economic issues, then all of the licensees named or alleged will be apportioned 0% of the amount of settlement.

Otherwise, within 10 business days of the settlement decision, the County's Third Party Claims Administrator shall prepare a copy of the medical record, a copy of the complaint(s), a copy of the County Counsel's determination on the factors for settlement, a copy of the relevant deposition summaries, a copy of the relevant deposition transcripts, and a copy of the Trial

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SUPERSEDES: June 1, 2009

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Counsel Report including the Final Summary of Potentially Reportable Licensees, taking care to exclude peer-review documents, and send such documents to HSAQIPS, who will forward them to the facility Medical Director/Nursing Director (or facility-designated group). The facility Medical Director/Nursing Director (or facility-designated group), will have 10 business days to review the documents and to provide the role and specific activities of each reportable licensee related to the factor(s) for settlement and relevant clarifying or explanatory documents, if desired.

Apportioning Process

At the end of the 10 business day period, HSAQIPS will return the documents and any additional information provided by the facility Medical Director/Nursing Director (or facility-designated group) to the County's Third Party Claims Administrator to forward to the apportionment consultant. (The County's designated apportionment consultant shall be an independent contractor with both medical and legal credentials). If the facility Medical Director/Nursing Director (or facility-designated group) prepares additional clarifying documents and forwards those to HSAQIPS within the 10 day time period, those documents will also be provided to the apportionment consultant. The County's apportionment consultant will recommend apportionment of the settlement attributed to any reportable named and alleged licensees identified by Defense Counsel in the Final Summary of Potentially Reportable Licensees, as well as, systems issues and economic factors, if any, that are identified.

The County's apportionment consultant shall review the applicable documents and render his/her written opinion as to the apportionment of liability within 10 business days of receipt of applicable documents.

The following principles provide decision making guidance to the apportionment consultant:

1. Residents are in training
2. Attending staff bear the responsibility for residents' care

The following are exceptions to the guiding principles that may be considered by the apportionment consultant when considering apportionment to a resident:

1. Resident disobeys clear instructions from a supervising physician
 2. Resident misrepresents clinical or other information to a supervising physician
 3. Resident fails to provide a level of clinical care or judgment that would be minimally expected of a resident at that level of training.
-

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The written opinion shall be forwarded to the HSAQIPS Director. HSAQIPS will forward this written decision to the facility Medical Director/Nursing Director (or facility-designated group). The facility shall notify each identified reportable licensee of the decision (Attachment II) including the total amount of the settlement and the amount attributed to each licensee. Notification may be in person, or by correspondence with confirmation in writing or by telephone including fax, email, letters or certified mail to last known address. The facility and licensee(s) shall have 30 business days to review and respond to the decision.

If the facility and licensee agree with the apportionment recommendation, or otherwise do not dispute the recommendation using the procedures set forth in this policy, that recommendation will be sent to the Director HSAQIPS, who will forward the decisions to the County's Third Party Claims Administrator. The amount of settlement apportioned to a potential reportable licensee, including zero, will be reported to the appropriate licensing board in accordance with Business and Professions Code Sections 801.01, et seq. The County's Third Party Claims Administrator shall prepare the appropriate documents to report said licensees to their respective boards. A copy of the report shall be forwarded to the DHS Director, the facility designee, and any licensees reported.

Dispute Resolution Process

If the facility and/or licensee does not agree with the apportionment recommendation, they/he/she will be afforded the opportunity to respond, in writing, and to provide additional clarifying information for dispute resolution as described below.

The initial dispute resolution process shall be to the apportionment consultant. The licensee(s) and/or facility shall have the opportunity, after receipt of the apportionment consultant's written recommendation, to dispute the recommendation by providing written clarifying documentation. The licensee(s) and/or facility shall provide that written documentation no later than the end of the 30 business days afforded for dispute resolution to the Director, HSAQIPS. Immediately upon receipt, the Director, HSAQIPS shall provide the documents to the apportionment consultant, who will have 5 business days to review the documents provided and modify the recommendation, if appropriate. The apportionment consultant shall provide a final written recommendation at the end of this 5 business day period or sooner to the Director, HSAQIPS. This apportionment consultant's final recommendation shall be forwarded to the facility Medical Director/Nursing Director, or facility-designated group. The facility shall forward the final recommendation to each licensee.

EFFECTIVE DATE: October 1, 2011

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DEPARTMENT OF HEALTH SERVICES COUNTY OF LOS ANGELES

SUBJECT: LICENSEE REPORTING TO LICENSING BOARD

POLICY NO.: 311.3

If a licensee does not agree with the apportionment consultant's final recommendation, he/she will be afforded the opportunity, to meet with the DHS Director and to provide additional documents relevant to the apportionment decision, including explanations of systems issues to the DHS Director within 15 business days of the licensee's receipt of the apportionment consultant's recommendation. The DHS Director will make a determination within 15 business days and inform the licensee, the facility and the Director, HSAQIPS.

If the facility does not agree with the final apportionment consultant's recommendations, it will also be offered an opportunity to present its concerns to this dispute resolution process which will include meeting with the DHS Director and providing relevant documents to the DHS Director within 15 business days of receipt of the recommendation. The DHS Director will make a determination within 15 business days and inform each licensee, the facility and the Director, HSAQIPS.

If the DHS Director's determination modifies the initial or final apportionment consultant's recommendation to increase the apportionment for any licensee, that licensee will be so notified and will be afforded an opportunity to meet with the DHS Director and to provide additional documents relevant to the apportionment decision, including explanations of systems issues to the DHS Director within 15 business days of the licensee's receipt of the DHS Director's modified apportionment recommendation. The DHS Director will make a determination within 15 business days and inform the licensee, the facility and the Director, HSAQIPS.

After all above dispute resolution processes have been completed, decisions by the DHS Director will be final.

In the event the DHS Director is privy to peer review information related to the case, a designee will be appointed to act for the DHS Director in the dispute resolution as defined above. This does not prevent the DHS Director from making the final determination of an agreed upon/non-disputed apportionment recommendation, as long as he or she makes no changes in the apportionment of any licensee.

Final decisions shall be provided to the Director, HSAQIPS who will forward the decisions to the County's Third Party Claims Administrator. The amount of settlement apportioned to a potential reportable licensee, including zero, will be reported to the appropriate licensing board in accordance with Business and Professions Code Sections 801.01, et seq. The County's Third Party Claims Administrator shall prepare the appropriate documents to report said licensees to their respective boards. A copy of the report shall be forwarded to the Director, HSAQIPS, the facility designee and any licensees reported.

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**DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES**

SUBJECT: LICENSEE REPORTING TO LICENSING BOARD

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The current reportable limits for each licensing board are as follows:

\$30,000	Medical Board of California
\$30,000	Osteopathic Medical Board
\$10,000	Board of Behavioral Sciences
\$10,000	Board of Psychology
\$10,000	Dental Board of California
\$3,000	State Board of Chiropractic Examiners
\$3,000	Board of Registered Nursing
\$3,000	Board of Vocational Nursing and Psychiatric Technicians
\$3,000	State Board of Optometry
\$3,000	Physical Therapy Board of California
\$3,000	Veterinary Medical Board
\$3,000	Pharmacy Board
\$3,000	Respiratory Care Board

(Flowchart of Process – Attachment III)

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