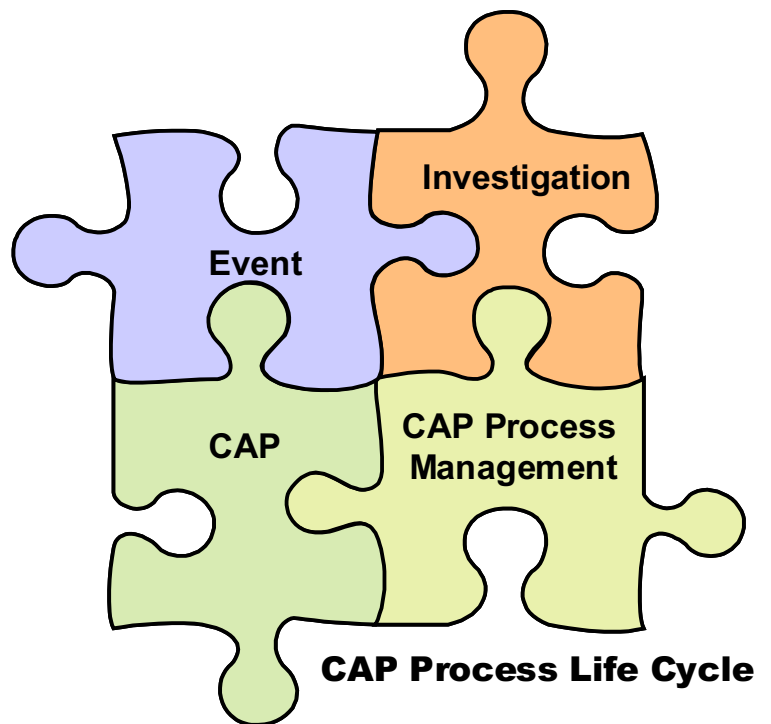


**County of Los Angeles
Chief Executive Office**

**Corrective Action Plan
User's Guide**



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Your comments on this guide are welcome. If you have any questions, or would like to request additional copies or related corrective action plan information, please contact:

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This *Corrective Action Plan User's Guide (User's Guide)* is intended for the use of employees of the County of Los Angeles, its departments and vendors. This is an unpublished work by the County of Los Angeles, Chief Executive Office, Risk Management Branch.

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Corrective Action Plan User's Guide

INTRODUCTION

CEO RISK MANAGEMENT INSPECTOR GENERAL (RMIG) PROGRAM

The County of Los Angeles is a large, complex government entity, and when tort liability events periodically occur, their root causes need to be identified and mitigated to prevent recurrence at a specific site, department, or countywide. The Board of Supervisors (BOS) ordered the creation of a program to develop, implement, and manage specific Corrective Action Plans (CAPs) for tort and contract liability settlements in excess of \$100,000 and Summary Corrective Action Plans (SCAPs) for settlements in excess of \$100,000. Since Fiscal Year (FY) 2003-04, the Chief Executive Office (CEO) Risk Management Branch (RMB) enhanced the County SCAP/CAP Program (Program), including developing training programs, providing specific loss control/root cause analysis consultation, reviewing Program documents for quality prior to BOS approval, measuring effectiveness/closure of completed SCAP/CAP steps, and communicating Program-related information.

In the event that a tort liability-related loss occurs, County management must immediately identify why the event occurred and implement steps to assure a similar or more severe outcome does not result from a future, similar causal event. The types of liability losses that impact the County are complex and range from medical malpractice claims, employment practices (discrimination, harassment, etc.), automobile liability, dangerous conditions, professional liability, and general liability (slips and falls, design defects, etc.) through law enforcement-related events (civil rights violations, use of force, etc.).

Due to the size and scope of the services provided by the County, a mechanism to investigate, correct, and communicate event root causes needed to be developed to ensure the identified root causes and implemented solutions abated/mitigated the hazards and were shared with other County departments with similar exposures.

When successfully implemented, a corrective action program can alter the internal culture of a department so that employees understand and accept that everyone is accountable for quality, cost avoidance, and liability minimization.

SCAP/CAP PROGRAM

The SCAP/CAP process involves thoroughly investigating a problem, initiating actions to correct the problem, and verifying that the correction was successful. The corrective action process involves:

- Identifying the problem;
- Researching/analyzing the problem's root causes (why it happened);
- Developing a plan to correct the problem and prevent recurrence;

- Executing the plan and verifying the plan was successful (monitoring the process); and
- Communicating “lessons learned” throughout the County.

Developing a management system to ensure that SCAPs/CAPs are correctly developed, implemented, and evaluated for closure/effectiveness requires participation and responsiveness from many different groups within the County. The goal is not to critique departments, but rather to work with them to find solutions. Ensuring the Program’s efficacy involves a number of critical components:

- Development of standard countywide procedures and policies outlining how the Program is implemented, measured, and managed (Note: CEO provided a User’s Guide to departments).
- Development of training programs and material to ensure consistent and efficient administration of the Program within all County departments (Note: CEO provided CAP training to more than 500 employees since 2004).
- Development of standard forms and instructions outlining how to research and develop SCAPs and CAPs.
- Development of a database for tracking and reporting on open and closed SCAP/CAPs and SCAP/CAP steps (Note: Database developed in 2004).
- Development of mechanisms to communicate SCAP/CAP root causes and provide corrective action steps to other County departments, and ensure proactive/preventative loss control options were implemented (Note: Posted on the Intranet and discussed at Risk Management Coordinators meetings and with individual departments).

WHAT TRIGGERS A SCAP/CAP

Departments will submit SCAPs and/or CAPs to RMIG 30 days prior to the Claims Board meeting and, for cases that are not reviewed by the Claims Board, the SCAP/CAP will be submitted no later than 30 days prior to the Board meeting where the settlement will be presented. However, the SCAP/CAP review by RMIG can occur earlier in the claim process. Without RMIG’s pre-approval, the SCAP/CAP will not be reviewed by the Claims Board and/or Board.

Cases involving settlements between \$20,000 and \$100,000 require the approval of the County Claims Board. In the Claims Board meetings, representatives from departments, County Counsel, and outside counsel present justifications for the proposed settlement amount and review corrective action steps designed to prevent recurrences. The Claims Board has three (3) appointed members from the Chief Executive Office, County Counsel, and Auditor-Controller. The County Risk Manager is the CEO member of the Claims Board.

For claims with settlement amounts greater than \$100,000, the Claims Board refers such settlements, with a recommendation, to the BOS for final action. At that time, the BOS will then approve or deny the final settlement and CAP. The BOS can elect to approve the settlement and defer approval of the CAP if it deems that further review is required.

MANAGING SCAP/CAP DEVELOPMENT

RMIG manages SCAPs and CAPs through the following process:

- Conducts a detailed analysis of incident reports, claims, significant incidents and adverse events, including monitoring adverse verdicts and items reported in the press;
- Attends Cluster and Client Review meetings, roundtables, and claim reviews;
- Consults with departments and assists them in developing SCAPs and CAPs as soon as practicable;
- Pre-approving all SCAPs and CAPs prior to submission to the Claims Board and/or Board of Supervisors.

RMIG also participates in all cluster meetings which involve in-depth discussions of CAPs and case facts, and at which Board Deputies, departments, County Counsel, and CEO attend. The purpose of these meetings is to brief the Board Deputies on all relevant information so they can brief their Supervisors before final Board approval is sought for a case.

As part of best practices to prevent similar losses from occurring in the same department, or in a different department with similar exposures, RMIG both publishes and presents Applicability Notices on a quarterly basis. The Applicability Notices are summary level documents that describe the incident, the root cause analysis of why it occurred, and the CAP steps for correcting the root cause(s) and preventing a repeat incident. Presentations are held at the Risk Management Coordinators quarterly meetings and notices are published on the CEO/RMB website.

FREQUENTLY ASKED QUESTIONS

What is a CAP?

A CAP is a Corrective Action Plan where one or more correction action steps are identified and placed in a formal document in order to correct a problem/incident which has occurred.

When should a CAP be written?

A CAP should be written as soon as possible after the incident occurs. A CAP should be written after identifying the root cause(s) of the incident and corrective action steps should be implemented immediately following the identified solution.

Should you wait until the case is settled?

No, a CAP is not claims/litigation driven, but loss control driven. Once you know of an issue you should try to resolve it immediately to avoid further losses. In considering litigation and

confidentiality issues, County Counsel should always be advised on when the final document can be drafted and signed. Thus, many of the corrective action steps can be implemented even though the actual final document may not yet be completed.

The process of investigating adverse events, identifying root causes, selecting and implementing appropriate corrective actions, and monitoring their implementation should start as soon as the department becomes aware of an adverse event. CAPs and SCAPs should be developed well in advance of most settlements.

BENEFITS OF THE SCAP/CAP PROCESS

The County's employees, residents, vendors, and contractors are protected by preventing the number of events that could have resulted in bodily injury or property losses. This is brought about by the SCAP/CAP contribution to the process by effecting:

- A reduction in the frequency (number of cases) and severity (cost) of adverse events related to County facilities, services, or programs; and by
- A reduction in the lag time between event occurrence, investigation, and SCAP/CAP development; an increase in the quality of SCAP/CAPs developed by departments; and, a stronger/more robust countywide liability loss control program.

HOW RMIG AND CAP PROGRAMS WORK WITH COUNTY OPERATIONS

CHIEF EXECUTIVE OFFICE RISK MANAGEMENT BRANCH (CEO/RMB)

RMIG reports to the County Risk Manager, who manages the CEO/RMB. RMIG and the SCAP/CAP Programs benefit by reporting to the CEO/RMB. CEO/RMB manages claims and claim information, loss control activities, and strategic risk initiatives. This gives RMIG the context and resources for managing the CAP Programs. Additionally, belonging to the CEO organization gives RMIG a better understanding of overall County operations, resulting in more effective SCAPs and CAPs that take into consideration the complexity of the County's long term goals and daily activities.

DEPARTMENTS

RMIG and staff consistently strive to develop and maintain excellent relationships with all Departments. This assures that RMIG provides Departments the resources and support needed to successfully participate in the CAP Program. Relationships are developed through correspondence, on-site visits to Departments, and collective efforts when RMIG accompanies Departments to Cluster Meetings, Client Reviews and Round Tables.

COUNTYWIDE CORRECTIVE ACTIONS

In response to the settlement of two claims with far-reaching impact in the areas of employment practices and the Fair Labor Standards Act, the Board of Supervisors asked CEO to develop a Countywide CAP process.

The development of Countywide CAPs involved collaboration between CEO/RMIG, County Counsel, Human Resources (DHR), Auditor-Controller, and CEO. Specifically, for the Fair Labor Standards Act claim, a mandatory training session was developed and implemented for all County supervisors and managers. For the two employment practices claims which involved sexual harassment and investigation of employees, respectively, Countywide corrective actions included reinforcement of existing training programs and the creation of the County Equity Oversight Panel, which deals with all types of discrimination.

Under the direction of the BOS, and in concert with DHR and County Counsel, CEO/RMB created the first Countywide Corrective Action Plan documents. An extension of department-specific Corrective Action Plans, the Countywide Corrective Action Plans address claims and exposures with Countywide impact, and provide specific guidance to all departments on identifying and preventing similar claims and exposures in their respective units.

ROOT CAUSE ANALYSIS PROCESS

DEFINITIONS

Terminology is important to understand the root cause analysis process. The following definitions display the sequence of events before an accident or incident occurs and the steps taken after:

- Hazard:** A condition, action, or lack of an action with the potential for causing an accident or loss.
- Undesired Event:** The event that precedes the loss; the contact that could or does cause the harm or damage to anything in the work or external environment.
- Loss:** The result of an accident is loss. Loss can range from harm to people and property, as well as performance interruption, quality degradation, environmental damage and profit reduction. Once the sequence has occurred, the type and degree of loss are somewhat a matter of chance. The effect may range from insignificant to catastrophic.
- Immediate Cause:** The specific act or condition which resulted in the incident; the circumstances that immediately precede the contact. Can also be called the “symptom” of the underlying problem. These are based on substandard acts and substandard conditions (example: person slipped in a puddle of oil).
- Root Cause:** The specific item(s) (also called basic cause) that, when corrected, would result in long-term prevention of similar accidents, incidents or events. This could be looked at as the underlying problem which causes the symptoms or immediate causes of the problem. This is the reason the substandard acts and conditions occurred. This is based on personal factors and job/system factors (example: the oil puddle was caused by a leaking pipe which was not properly installed and maintained. The basic cause of the oil on the floor was problems with installation and maintenance).
- Control:** Control is one of the four essential risk management functions, which are plan, organize, lead and control. In a loss prevention context, control of loss involves inadequate systems, inadequate standards, and inadequate compliance with standards.

BENEFITS

The benefit and importance of determining the root causes of the incident/event is to develop a plan to prevent recurrence. However, this is not the only benefit a department can gain from conducting a thorough and professional root cause analysis. Information is a powerful risk management tool. The information gathered during root cause analysis can be used for many purposes, which include, but are not limited to, the following:

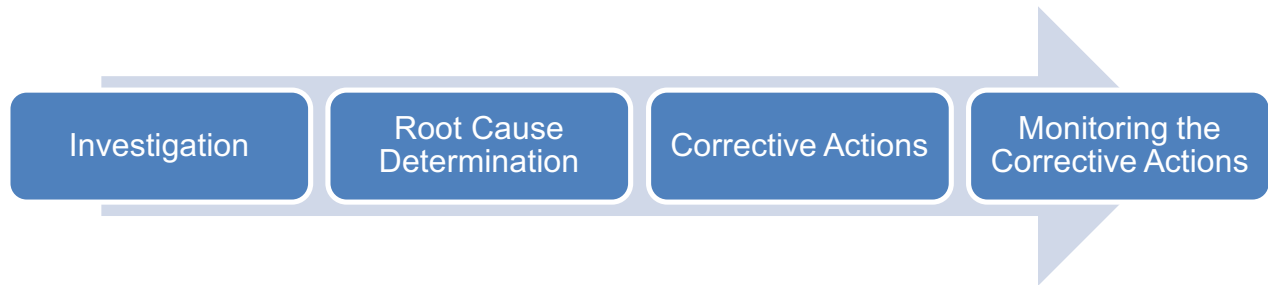
- To provide preventive measures on other aspects of County business processes (i.e., fleet operations, property protection, rights of employees, etc.).
- To satisfy legal or regulatory requirements for claims and litigation management activity.

- To provide answers to “why” the event occurred and initiate more in-depth questions to find root causes.
- To build departmental awareness and communicate best practices.
- To build consensus on found problems and corrective actions and provide for easier buy-in with regards to corrective actions.
- To comply with Cal/OSHA Injury and Illness Prevention Program (IIPP) requirements.

SCAP/CAP PROCESS STEPS AND COMPONENTS

Before any root cause analysis is conducted, the initial response to any accident or incident should be to address the immediate hazard(s). After that process, it moves into accident/incident investigation. Once the investigation is conducted, the process progresses onto the root cause determination, then to developing solutions or corrective actions, and then monitoring of corrective actions.

In any part of the process where a deficiency is found, the process can be repeated and a better solution can be found. For example, if a corrective action is implemented and through corrective action monitoring it does not prevent a similar accident/incident from occurring, the risk manager will have to repeat the process and investigate again for the root cause.



INVESTIGATION

The first part of this process is to identify your key personnel and subject matter experts. The department will need a lead person(s) to assign parts of the investigation to others in the department and to keep track of the investigation. Once assignments are established, the lead person(s) will conduct the root cause determinations through various methods, never limiting themselves to finding the facts.

KEY PERSONNEL

To better understand the process, the following is a list of key personnel and subject matter experts, and their involvement in the investigation.

Roles in the Investigation Process	
Investigator	Reasons
Supervisor	<ul style="list-style-type: none"> Incident reporting and notification (workers' compensation, etc.) Initial hazard abatement Policy/procedure requires initial review of facts
Department Safety Officer	<ul style="list-style-type: none"> Cal/OSHA investigation/notification

	<ul style="list-style-type: none"> • Hazard abatement and abatement follow-up/closure • Senior management reporting
Senior Management	<ul style="list-style-type: none"> • SCAP and/or CAP development • “Lessons learned” reporting and communication • Determination of the future of affected process (catastrophic loss) • Communication with the public (catastrophic loss) • Determine Board response
Third Party Claims Adjuster	<ul style="list-style-type: none"> • Determine liability and exposure • Determine third party responsibility and subrogation potential • Establish claim cost reserves and build claim file
Third Party Insurance	<ul style="list-style-type: none"> • Determine liability and exposure for involved third party • Establish claim cost reserves and build claim file • Litigation preparation • Subrogation potential
Legal Counsel	<ul style="list-style-type: none"> • Determine liability and exposure • Build litigation defense • Establish confidentiality protection (if applicable)
Risk Management Inspector General	<ul style="list-style-type: none"> • SCAP and/or CAP development • “Lessons learned” reporting and communication • Impartial and independent review of circumstances leading to event
Law Enforcement/ Fire Department	<ul style="list-style-type: none"> • Criminal/civil investigation • Determination of code violations
Press Release	<ul style="list-style-type: none"> • Fact determination for reporting purposes

The major points in an investigation are listed below by priority:

1. Handle any emergency and make sure all involved parties receive medical attention, if needed.
2. Secure the scene, if needed.
3. Inspect the accident/incident scene and gather necessary physical evidence (i.e., damaged equipment, photographs, etc.).
4. Interview people who may have witnessed the event. Be professional and respectful, investigations are for fact finding and not fault finding.
5. Interview injured people, if possible.
6. Review applicable policies, procedures, regulations and guidelines related to the factors leading to the event.
7. Review existing records, as necessary (i.e., training and inspection records).
8. Analyze all the facts with methods from the next section to determine the root cause, corrective actions, and monitoring solutions.

ROOT CAUSE DETERMINATION

The following are methods to determine the root cause, corrective actions, responsible parties, solutions, and solution monitoring.

THE 5 WHY APPROACH

Repeatedly asking the question "Why" (five is a good rule of thumb) can stimulate an in-depth line of questioning which can lead to the root cause of a problem. Very often the apparent reason for a problem will lead you to another question. Although this technique is called "5 Whys," you may need to ask the question more than five times before you find the issue related to a problem. The 5 Why Approach is most useful when the problems involve human factors or interactions to their environment.

The following are steps to the line of questioning:

1. Write down the specific problem. Writing the issue helps you formalize the problem and describe it completely. If an investigation team is organized, it helps the team focus on the same problem.
2. Ask "Why the problem happened" and write the answer down below the problem.
3. If the answer you just provided does not identify the root cause of the problem you wrote down in step 1, ask "Why" again and write that answer down.

4. Loop back to step 3 until the team is in agreement that the problem's root cause is identified. Again, this may lead to asking more than five whys.

A 5 Why example:

Problem: The Washington Monument was disintegrating.

1. Why? Use of harsh chemicals
2. Why? To clean pigeon droppings
3. Why so many pigeons? They eat spiders and there are a lot of spiders at monument
4. Why so many spiders? They eat gnats and lots of gnats at monument
5. Why so many gnats? They are attracted to the light at dusk

Solution: Turn on the lights at a later time, which does not attract the gnats at dusk, which minimizes the amount of spiders due to a lack of a food source, which minimizes the amount of pigeon and their dropping resulting in a lower amount of harsh chemicals being used. Do not limit your analysis at this point. There is no limit to the amount of questions. If this does not work, repeat the process.

PEOPLE VS. SYSTEMS

There are two types of causal factors when looking at the facts of an investigation.

1. People or Actions: These are actions that people act upon or fail to act upon during a situation. This cause is typically a human error.
2. System or Conditions: These are the environment or conditions in which an action has happened.

Employees can cause accidents by not following directions nor adhering to safety policies and procedures. Some examples include omitting a safety guard, being tired, or being careless or rushing a task. Systems can cause accidents by having poorly designed equipment, procedures that lack safety controls, or purchasing faulty tools and mechanisms. Often, accidents occur due to a combination of People and Systems failures.

During an investigation, employee error might be the initial assumption and where investigators might stop looking. However, this can be an immediate cause or a symptom of a cause, but not the root cause. By evaluating the system that the employee is connected to, investigators can step back and look at the system globally.

A People vs. Systems example:

Problem: The Washington Monument was disintegrating.

People

1. Employees did not evaluate the harsh chemicals being used and their effects on the monument.
2. Employees did not notice the early stages of disintegration of the monument.

Systems

1. The monument location and size was not evaluated for biological and environmental hazards when built.
2. There was no policy or procedure to do a periodic inspection of the monument for damage and for evaluating all monuments based on biological and/or environment hazards.
3. There is no system to record damage on monuments and to address the problems at an earlier time.

Solution: Establish a system to evaluate all monuments and a process to address problems at an earlier stage of the damage. Train employees to identify damage on the monuments and to substitute a chemical that does not damage monuments.

CONNECTION BETWEEN BOTH INVESTIGATION METHODS

Each case scenario is going to be different and will require the investigator to be creative. One method might work for one situation, but not the other one, and sometimes both methods will not work together. The investigator will have to experiment and build upon methods that work well for the situation. For example, if you notice from the *5-Whys* and *People vs. Systems* examples, both methods need to be used in conjunction to get the whole story or to find the deeper root causes. Do not limit your investigation to just one method.

The following are some examples of the thought process using both investigation methods. Please note, although taken from real case scenarios, some details are fictional.

Case #1 Employment Practices

This is an employment practices liability case, wherein the plaintiff, a female janitor, alleges that throughout her employment, her supervisor created a sexually hostile work environment by showing her naked pictures of himself, touching her in an uninvited unwanted and offensive manner, and putting his hands on her body including her breasts. She claims that he also threatened her job if she did not give in to his sexual demands by reminding her that he was the one who hired her and the one who could fire her. Finally, she maintains that when she complained of the offensive treatment, nothing was done to investigate it or stop it.

5 Whys

1. Why was this going on? *Employee did not know her rights or who to contact outside of her supervisor.*
2. Why did the employee not know her rights? *She was not trained during a new job orientation nor had any refresher training on sexual harassment.*
3. Why was nothing done if in fact she did report? *It was confirmed through records that nothing was reported.*
4. Why was the supervisor doing this? *Supervisor was trained and knew County policy on harassment, but was lonely and abused his authority.*
5. Why did the manager not know about the supervisor's actions? *The manager is at a different location back at HQ while the supervisor is at a field location.*
6. Etc., keep asking questions.

People vs. Systems

People

Look at human error in this case:

- Supervisor should not have been harassing the employee.
- Employee should have been reporting the harassment.
- Manager did not visit remote sites.

Systems

- Department does not have a system to train all employees on County policy, especially new employees.
- Department needs to reevaluate their training curriculum and ensure it is effective.
- Department does not have a system to automatically enroll all employees in refresher training.
- Department does not have a point of contact in HR if the employee fears the supervisor.
- Department managers are not seen often at field locations and field locations are secluded from HQ.

Solution

Each of the issues that are described will require a corrective action.

Case #2 Automobile Liability

This is an automobile liability case, wherein on January 7, 2009, a fatality occurred during a traffic accident. The decedent was operating a 2008 Harley Davidson Sportster at 5:48 a.m. The weather was clear and dry. Two employees were traveling in a County owned truck on their way to a County training, west bound on the 10 Freeway near the Sunset off ramp when the driver attempted to make a lane change from the #1 lane to the #2 lane. While making the lane change, the County vehicle was struck by a motorcycle on the right hand side. As a result of the impact, the motorcyclist fell off of his bike and was consequently ran over and killed by a semi truck and trailer who was traveling in the #3 lane.

5 Whys

1. Why did this happen? *The County driver did not see the motorcyclist before changing lanes.*
2. Why did he not see the motorcyclist? *He was only looking for cars in the other lane before the lane change. He also checked his passenger side mirror twice, but no mention of checking his blind spot.*
3. Why did he not check for motorcyclist and the blind spot? *He was not trained to do so and was unfamiliar with the truck.*
4. Why was he unfamiliar with the truck? *He only drives when he needs to attend training and rarely drives the truck.*
5. Why was the motorcycle so close to the truck? *The motorcyclist was splitting lanes and we found out that he does not have a M1 license.*
6. Etc., keep asking questions.

People vs. Systems

People

Look at human error in this case:

- County driver did not look at the blind spot before making a lane change.
- County driver was not aware of the motorcyclist before making a lane change.
- County driver has had three vehicle accidents in the last two years and had a suspended license.
- Motorcyclist was splitting lanes not in a safe and prudent manner based on the speed of traffic.
- Motorcyclist did not have a M1 license to drive the motorcycle.

Systems

- Department did not train or orient employees on different vehicle types, like trucks with utility beds, their size differences, blind spots, etc.
- Department did not check employee's license on a periodic basis to see if it was valid or not.
- Department does not have a defensive driver training for employees when hired nor refreshers.
- Department does not conduct a DMV check at the time of hire nor a check to ensure

existing employees have valid licenses.

- Department does not have any policies or procedures on what to do after vehicle accidents. For example, which County forms to complete or who to call.

Solution

Each of the issues that are described will require a corrective action.

Case #3 General Liability

This is a general liability accident, wherein on September 23, 2007, Plaintiff, age fifty-one, claims she was walking southbound on the west side of a street in Los Angeles, when she tripped and fell over a raised and broken sidewalk slab. The plaintiff claims that this raised and broken sidewalk slab constituted a dangerous condition of property.

5 Whys

1. Why did this happen? *Plaintiff was talking on her cell phone and did not notice the raised and broken sidewalk slab.*
2. Why was the sidewalk damaged? *The department was not aware of the damaged sidewalk.*
3. Why was the department not aware? *There is no method to inspect sidewalks and the Department assumed it was the City's property.*
4. Why was it assumed it was the City's property? *For years, no one had questioned it and assumed it to be the City's property.*
5. Why was the information not confirmed? *Managers were not concerned about the issue because they have never had a problem before and it has never been brought up in the Department.*
6. Etc., keep asking questions.

People vs. Systems

People

Look at human error in this case:

- The plaintiff did not watch where she was going.
- Ground maintenance employees did not report the damaged sidewalk.
- Ground maintenance employees did not repair the damaged sidewalk.

System

- There are similar cases of slips, trips, and falls resulting from damaged sidewalks in other departments, but no active communication between departments on what to do with broken and raised sidewalks. This department did not know how to be proactive in dealing with the damaged sidewalks. There was no Countywide communication or applicability.
- Department had no formal method of inspection, repair, and tracking of damaged sidewalks.
- Department did not have confirmed liability to whose responsibility it was to maintain the

sidewalk, the City or County.

- Department managers did not analyze the liability or workers' compensation data periodically to find trends in problem areas of the Department.

Solution

Each of the issues that are described will require a corrective action.

CORRECTIVE ACTIONS

Once the information is gathered and the root cause analysis has been done, the next step is to develop corrective actions and control identified hazards. Selecting an appropriate corrective action is not always easy. Choosing a corrective action may involve:

- Evaluating and selecting temporary and eventually permanent hazard controls
- Implementing temporary measures until permanent hazard controls can be put into place
- Implementing permanent hazard controls when reasonably practicable

CONTROLS

The main way to control a hazard is to include the following:

- **Elimination (or substitution):** removing the hazard from the workplace and deciding whether or not to take a business risk (i.e., procedure, personnel, tools, operations, etc.).
- **Engineering Controls:** includes designs or modifications to the department's structure (i.e., hiring requirements for employees, computer modifications, design in sidewalk materials, etc.).
- **Administrative Controls:** altering the way the work is done, including the timing of work, procedures and policies, and work practices (i.e., employment practices, effective training, investigation procedures, etc.).

SMART CORRECTIVE ACTIONS

The final evaluation of the proposed corrective action steps and hazard controls can be done through a set of objectives based on the mnemonic word: **SMART**. Ensure to always define your purpose before beginning to write each corrective action step.

- **Specific:** this stresses a need for a specific corrective action and against a more general one. This means the corrective action is NOT ambiguous, but clear and detailed.

Non-Specific: train all employees in a sexual harassment prevention class

Specific: train all line supervisors and managers in two phases:

1. sexual harassment prevention for supervisors by January 2015
2. sexual harassment prevention for managers by March 2016

- **Measurable:** this stresses a more concrete criterion for measuring the progress of a corrective action. This incorporates the thought that if the corrective action is not measurable, it is not possible to determine whether or not the department is making progress. For example, how many employees is a department going to train and how will I know when it is accomplished and by when?

Non-Measurable: inspect facilities for slip, trip, and fall hazards.

Measurable: develop a facility inspection schedule to assure each facility is inspected once every quarter, documenting date of inspection, hazards if any, and responsible party follow-up activities.

- **Attainable**: this stresses the importance of the corrective action to be realistic and attainable. It is ineffective when a correction action plan may stretch a department's resources or not enough corrective action to solve the problem. An attainable corrective action will answer the question: how can the corrective actions be accomplished?

Non-Attainable: obtain the funding from the CEO to repair all hazards found in the facility inspection reports.

Attainable: prioritize all hazards found in the facility inspection reports based on hazard correction matrix (probability vs. severity) and propose funding requests to budget/fiscal with justification for the corrective actions.

- **Realistic**: this stresses the importance of making the corrective action relevant. It has to be worthwhile for the department to complete the corrective action based on the root cause analysis.

Non-Realistic: eliminate 100% of all vehicle accidents and increase the miles driven for the department.

Realistic: investigate 100% of vehicle accidents and depending on outcome of the root cause analysis, provide initial and refresher training, discipline, and review of assignments, as appropriate.

- **Timely**: this stresses the importance of grounding corrective actions within a doable timeframe. This is where the corrective action is given a target date and a commitment to complete. Consider basing timelines on frequency of exposure, severity and likelihood of harm, or probability of occurrence. Immediate or imminent hazards should be addressed as soon as possible and others should be addressed as feasibly possible.

Non-Timely: over a one year period, for every department driver who is involved in an at-fault accident, the department will write a SCAP for each of the accidents. The department has an average of 500 at-fault accidents per year.

Timely: in the first quarter of the year, a trend of the department's at-fault accidents is identified, through root cause analysis and SCAPs. In the second quarter, a defensive driving training program is implemented. In the third and fourth, monitoring of accidents and effectiveness of corrective actions are documented.

Please note that a SMART process assists in blueprinting a corrective action, but not achieving your corrective action. The last component of the solution and correction action process is the following:

- Chew smaller bites. Piecemeal the corrective action steps and be detailed in each process with assigned dates. This will assist in completing a sometimes overwhelming process.
- Start today. The plan of action must begin with an item that can be accomplished the same day. (i.e., assigning HR to the corrective action, forwarding documents for review, etc.)
- Assign responsible persons to be accountable for the corrective actions.
- Assign a monitor to evaluate and re-evaluate corrective actions to ensure they are effective or not.
- Prepare for failure. If corrective action A does not work, ensure to get ready for a plan B.

MONITORING THE CORRECTIVE ACTIONS

It is important to know if your causal factor process, solutions, and corrective actions were complete and accurate. By monitoring both the hazards and the control methods the department is ensuring that the control is effective and the exposure to the hazard is reduced or eliminated. It is also essential to ensure that these new corrective actions have not introduced any new hazards in the workplace.

Some monitoring tools include physical inspection, exposure assessment, observations, employee feedback/input, injury and illness tracking, process audit and other methods. The monitoring process can also be evaluated to see if they are adequate. Monitoring is the final step to an ever-changing process.

RESOURCES

In order to complete a comprehensive investigation and root cause determination additional resources or analytical approaches may be needed to support the investigative process. Depending on the severity and complexity of the loss occurrence, numerous technical professionals and/or technical analyses may be needed in hazard recognition. These include, but are not limited to:

- Accident reconstruction
- Engineering design review
- Industrial hygiene assessments
- Ergonomic/human factors assessments
- Accident imaging
- New equipment/process reviews
- Medical evaluations
- Legal analysis
- Task, job or process analysis
- Inspections (property, process or procedures)

The following is a list of CEO Risk Management Branch (RMB) resources for departments to tap into when developing their SCAPs/CAPs:

- Risk Management Inspector General
RMIG@ceo.lacounty.gov
(213) 738-2194
- Loss Control and Prevention
http://riskmanagement.mylacounty.info/lcp_cu.asp
- CEO RMB Intranet site: <http://riskmanagement.mylacounty.info/>

SUMMARY CORRECTIVE ACTION PLAN (SCAP)

THRESHOLD

The SCAP is based on tort indemnity settlements in excess of \$100,000.

Note: Medical malpractice monetary settlements which are less than \$100,000 do NOT require a SCAP.

DEPARTMENT'S INPUT AND ACTIONS

The following is a checklist of items that are involved in the SCAP process:

<input type="checkbox"/>	Receive monthly open/close liability claims report. These reports are organized by general liability (GL), automobile liability (AL), and medical malpractice (MM).
<input type="checkbox"/>	Receive email from County Counsel (CC) requesting investigation, documents, and policies and procedures in regards to the claim.
<input type="checkbox"/>	Attend roundtable meetings with CC, third party administrators, CEO Small and Property Claims, and/or RMIG. The roundtable provides additional information and discussion on the claim.
<input type="checkbox"/>	Receive Case Management Reports from CC.
<input type="checkbox"/>	Receive Litigation Management Updates from CC.

PROCESS

Once the department has the inflow of information and requests, the following is a checklist of actions to take:

<input type="checkbox"/>	Gather information from subject matter experts of affected sections. Ask the right questions and serve as the hub for information.
<input type="checkbox"/>	Conduct a root cause analysis with the gathered information. Communicate with the subject matter experts and agree on a root cause(s) to the claim.
<input type="checkbox"/>	Develop corrective actions and assign responsible parties to complete the actions.
<input type="checkbox"/>	Request for assistance anytime during the process before <u>CEO Risk Management Inspector General (RMIG)</u> approval and signature.

<input type="checkbox"/>	Submit the SCAP to the <u>RMIG</u> for approval and signature. If changes need to be made based on the RMIG review and discussion, resubmit the SCAP to the RMIG for final signature.
<input type="checkbox"/>	Submit the SCAP original copy to <u>CC</u> after the RMIG approval and signature. After CC receives the SCAP, the <u>Claims Board</u> will review and do the final approval.
<input type="checkbox"/>	Monitor the corrective actions to ensure they are effective and completed. If the corrective actions do not solve the problem, re-evaluate the situation.

DOCUMENTS

The following is a list of documents the department will need to complete the SCAP process and conduct analysis on the data.

<input type="checkbox"/>	<u>SCAP Template</u> – submit to RMIG as soon as possible and at least 30 calendar days before the Claims Board review. The SCAP is written in a public document format (non-confidential). Only exception is for employment-related claims which will be written in a confidential format.
<input type="checkbox"/>	Record corrective action steps and implementation. The monitor should keep track of effective or ineffective correction action steps. Any ineffective correction action steps will require a re-evaluation of the root cause and solution.
<input type="checkbox"/>	Record all claims and developed SCAPs in a database, spreadsheet, or dashboard. This will provide statistical information for analysis of trends or patterns of risk areas within the department.

RMIG INVOLVEMENT

The following are services and support that RMIG can provide to departments during the SCAP process:

- Consulting with departments who need assistance with developing corrective actions and SCAPs.
- Reviewing, approving, and signing SCAPs.
- Providing resources where a department can find information to assist them in the SCAP.
- Requesting a SCAP following an adverse jury verdict to be submitted within 45 days of the request.

CORRECTIVE ACTION PLAN (CAP)

THRESHOLD

The CAP is based on tort indemnity settlement amount above \$100,000. However, simultaneously the preparation of the SCAP should be concurrent with the CAP process.

DEPARTMENT'S INPUT AND ACTIONS

The following is a checklist of items that are involved in the CAP process:

<input type="checkbox"/>	Receive monthly open/close liability claims report. These reports are organized by general liability (GL), automobile liability (AL), and medical malpractice (MM).
<input type="checkbox"/>	Receive email from County Counsel (CC) requesting investigation, documents, and policies and procedures in regards to the claim.
<input type="checkbox"/>	Attend roundtable meetings with CC, third party administrators, CEO Small and Property Claims, and/or RMIG. The roundtable provides additional information and discussion on the claim.
<input type="checkbox"/>	Receive Case Management Reports from CC.
<input type="checkbox"/>	Receive Litigation Management Updates from CC.

PROCESS

Once the department has the inflow of information and requests, the following is a checklist of actions to take:

<input type="checkbox"/>	Gather information from subject matter experts of affected sections. Ask the right questions and serve as the hub for information.
<input type="checkbox"/>	Conduct a root cause analysis with the gathered information. Communicate with the subject matter experts and agree on a root cause(s) to the claim.
<input type="checkbox"/>	Develop corrective actions and assign responsible parties to complete the actions.
<input type="checkbox"/>	Submit the CAP to the <u>CEO Risk Management Inspector General (RMIG)</u> for approval. If changes need to be made based on the RMIG review and discussion, resubmit the CAP to RMIG for approval.

Submit the CAP original copy to CC after the RMIG approval. After CC receives the SCAP, the Claims Board will review and approve. After Claims Board approval, the Board of Supervisors will review and conduct the final approval. At each step, if either the Claims Board or Board of Supervisors requires changes to the CAP, the department will comply and resubmit.

Monitor the corrective actions to ensure they are effective and completed. If the corrective actions do not solve the problem, re-evaluate the situation.

DOCUMENTS

The following is a list of documents the department will need to complete the CAP process and conduct analysis on the data.

CAP Template – **submit to RMIG as soon as possible and at least 30 calendar days before the Claims Board review.** The CAPs are written in a confidential format.

Record corrective action steps and implementation. The monitor should keep track of effective or ineffective correction action steps. Any ineffective correction action steps will require a re-evaluation of the root cause and solution.

Record all claims and developed CAPs in a database, spreadsheet, or dashboard. This will provide statistical information for analysis of trends or patterns of risk areas within the department.

RMIG INVOLVEMENT

The following is a list of services and support that RMIG can provide to departments during the CAP process:

- Consulting with departments who need assistance with developing corrective actions and CAPs.
- Reviewing and approving the CAPs.
- Providing resources where a department can find information to assist them in the CAP.
- Requesting a CAP following an adverse jury verdict to be submitted within 45 days of the request.

COUNTYWIDE CORRECTIVE ACTION PLAN (CWCAP)

THRESHOLD

The CWCAP is based on any settlement amount.

DEPARTMENT'S INPUT AND ACTIONS

The following is a checklist of items that starts the process of the CWCAP:

- | |
|--|
| <input type="checkbox"/> Determine if the Department's SCAP corrective actions are applicable to other divisions within that department (Systemwide) or to other County departments (Countywide). If so, the Department checks the box on the SCAP to signify that it has potential applicability beyond Department. |
|--|

PROCESS

Either RMIG or Executive Management may initiate CWCAP. If RMIG initiates or is asked to coordinate the CWCAP, the following is a checklist of CWCAP related tasks:

- | |
|---|
| <input type="checkbox"/> Validate the department's information pertaining to Systemwide and/or Countywide applicability. Determine if there are SCAPs from other Departments with similar facts and applicability that should be incorporated in the CWCAP. |
| <input type="checkbox"/> Assist and coordinate Executive Management or key departments such as Chief Executive Office, Department of Human Resources, or Auditor-Controller with details on the applicable SCAPs. |
| <input type="checkbox"/> Under the direction of Executive Management or key departments, steward the process as required and record any outcomes. |

DOCUMENTS

The following will be a document in which departments will be able to view and possibly use if applicable to their operations.

- | |
|---|
| <input type="checkbox"/> <u>CWCAP</u> – developed by Executive Management, departments and the CEO. |
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