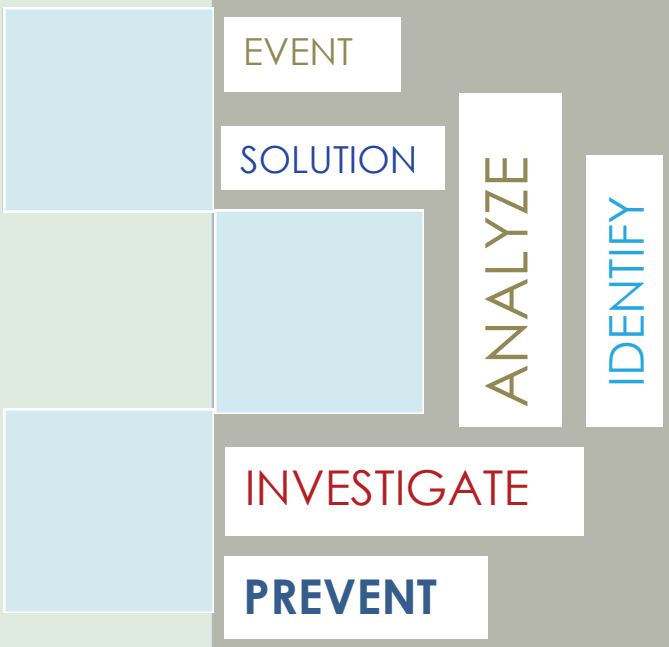
RISK MANAGEMENT
Los Angeles County Chief Executive Office

Corrective Action Plan User Guide

CAP Process Life Cycle



County of Los Angeles
Chief Executive Office—Risk Management Branch
Risk Management Inspector General

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Table of Contents

INTRODUCTION

CHIEF EXECUTIVE OFFICE RISK MANAGEMENT INSPECTOR GENERAL PROGRAM

The County of Los Angeles (County) 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 Department or site Countywide. The Board of Supervisors (Board) ordered the creation of a program to develop, implement, and manage specific Corrective Action Plans (CAPs) and Summary Corrective Action Plans (SCAPs) for tort and contract liability settlements in excess of $100,000. Since Fiscal Year (FY) 2003-04, the Chief Executive Office (CEO) Risk Management Branch (Risk Management) enhanced the County CAP and SCAP Program (Program), including developing training Programs, providing specific loss control/root cause analysis consultation, reviewing Program documents for quality prior to Board approval, measuring effectiveness/closure of completed CAP and SCAP 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 event. The types of liability losses that impact the County are complex and range from medical malpractice; 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; therefore, employees understand and accept that everyone is accountable for quality, cost avoidance, and liability minimization.

CORRECTIVE ACTION PLAN AND SUMMARY CORRECTIVE ACTION PLAN PROGRAM

The CAP and SCAP process involves the thorough investigation of 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 CAPs and SCAPs 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 has provided a User 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 CAPs and SCAPs.

- Development of a database for tracking and reporting on open and closed CAPs and SCAPs, and CAP and SCAP corrective action steps.

  Note: Database was updated in 2015.

- Development of mechanisms to communicate CAP and SCAP root causes and provide corrective action steps to other County Departments, and ensure proactive/preventative loss control options are implemented.

  Note

  Steps have been posted on the CEO Risk Management Intranet site.

DEVELOP

IMPLEMENT

IDENTIFY

What Triggers a Corrective Action Plan and Summary Corrective Action Plan

Upon notification of a tentative settlement in excess of $100,000, RMIG will review the claim and pose questions to the Department, including those that reflect root cause analysis to be addressed in the CAP and SCAP. Departments will have **30** business days from County Counsel or Third-Party Administrator (TPA) notification of a tentative settlement to provide RMIG with a draft CAP and SCAP for review, which incorporates the root cause analysis questions, as well as Department corrective actions.

Upon receiving the draft CAP and SCAP from the Department, RMIG will contact the Department with any follow-up questions. Once Departments have adequately answered all questions, RMIG will provide approval of the CAP and SCAP and issue a notice to the Department.

Departments shall respond to all RMIG questions and finalize the CAP and SCAP for RMIG's approval no more than **90** business days from receipt of settlement notification. Upon receipt of RMIG's approval of the CAP and SCAP, the Department shall inform County Counsel the plans are completed and ready for submission to the County Claims Board or Board of Supervisors.

Approval Overview

Cases involving settlements between $20,000 and $100,000 require the approval of the 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 CEO, 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 Board for final action. At that time, the Board approves or denies the final settlement and CAP. The Board can elect to approve the settlement and defer approval of the CAP if deemed that further review is required.

MANAGING CORRECTIVE ACTION PLAN AND SUMMARY CORRECTIVE ACTION PLAN DEVELOPMENT

RMIG manages CAPs and SCAPs 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 Board Cluster meetings, Client Review meetings, roundtables, and claim reviews;
- Consults with Departments and assists them in developing CAPs and SCAPs as soon as practicable;
- Pre-approving all CAPs and SCAPs prior to submission to the Claims Board and/or Board.

RMIG also participates in all Board 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 via webinars, which are also published on the CEO Risk Management 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 that has occurred.

When should a CAP be written?

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

Should you wait until the case is settled?

No, a CAP is not claims-litigation driven, but is loss-control driven. Once the Department identifies an issue, it should try to resolve it immediately to avoid further losses. In considering litigation and confidentiality issues, County Counsel should always be consulted 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 must be developed well in advance of most settlements.

BENEFITS OF THE CORRECTIVE ACTION PLAN AND SUMMARY CORRECTIVE ACTION PLAN

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 CAP and SCAP contribution to the process by:

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

SOLUTION

STRATEGY

CONTROL

CHIEF EXECUTIVE OFFICE RISK MANAGEMENT BRANCH

RMIG reports to the County Risk Manager, within CEO Risk Management. CEO Risk Management manages claims and claim information, loss control activities, and strategic risk initiatives. This gives RMIG the context and resources for managing the CAP and SCAP Program. Additionally, under the umbrella of the CEO organization, gives RMIG a better understanding of overall County operations, resulting in more effective CAPs and SCAPs that take into consideration the complexity of the County's long-term goals and daily activities.

COUNTY DEPARTMENTS

RMIG 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 and SCAP Program. Relationships are developed through correspondence, on-site visits to Departments, and collective efforts when RMIG accompanies Departments to Board Cluster meetings, Client Review meetings, and roundtables.

REGULATE

CONTROL

MAINTAIN

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 asked CEO to develop a Countywide CAP process.

The development of Countywide CAPs involved collaboration between Department of Auditor-Controller, CEO, County Counsel, and the Department of Human Resources (DHR). 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 Board, and in concert with County Counsel and DHR, CEO Risk Management 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 locations.

ROOT CAUSE ANALYSIS PROCESS

DEFINITIONS

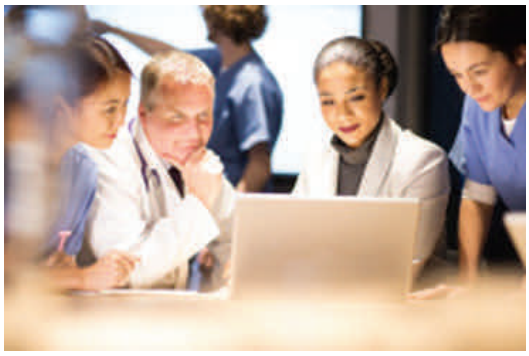
Terminology is important to understand the root cause analysis process. The following definitions display the sequence of events before an accident or incident occurs and the corrective action steps taken after the event:

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. 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 preceded the contact. Immediate Cause 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 and is based on personal factors and job/system factors (example: the puddle of oil 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 the California Division of Occupational Safety and Health Administration (Cal/OSHA) Injury and Illness Prevention Program (IIPP) requirements.



AWARENESS

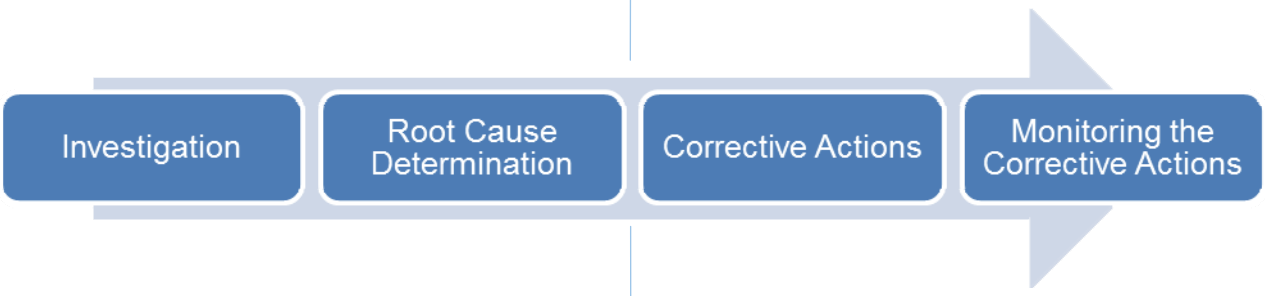
MITIGATION

DETERMINATION

CORRECTIVE ACTION PLAN (CAP) AND SUMMARY CORRECTIVE ACTION PLAN (SCAP) DEVELOPMENT

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, developing solutions or corrective actions, and monitoring

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 need 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 within the Department and 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	
Supervisor	⇒ Incident reporting and notification (workers' compensation, etc.). ⇒ Initial hazard abatement. ⇒ Policy/procedure requires initial review of facts.
Department Safety Officer	⇒ Cal/OSHA investigation/notification. ⇒ Hazard abatement and abatement follow-up/closure. ⇒ Senior management reporting.
Senior Management	⇒ CAP and/or SCAP 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	⇒ Determine liability and exposure. ⇒ Determine third party responsibility and subrogation potential. ⇒ Establish claim cost reserves and build claim file.
Third Party Insurance	⇒ Determine liability and exposure for involved third party. ⇒ Establish claim cost reserves and build claim file. ⇒ Litigation preparation. ⇒ Subrogation potential.
Legal Counsel	⇒ Determine liability and exposure. ⇒ Build litigation defense. ⇒ Establish confidentiality protection (if applicable).
Risk Management Inspector General	⇒ CAP and/or SCAP development. ⇒ "Lessons learned" reporting and communication. ⇒ Impartial and independent review of circumstances leading to event.
Law Enforcement/ Fire Department	⇒ Criminal/civil investigation. ⇒ Determination of code violations.
Press Release	⇒ Fact determination for reporting purposes.

INVESTIGATION

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.

RESEARCH

ANALYZE

EXPLORE

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 "The 5-Why," you may need to ask the question more than five times before you find the issue related to the 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 below the problem.
3. If the answer you just provided does not identify the root cause of the problem you wrote in step 1, ask “Why” again and write that answer.
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 Sample:

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 on the monument.*
4. Why so many spiders? *They eat gnats and there are lots of gnats on 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 food source, which minimizes the amount of pigeons 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; or

2. **System or Conditions**
   These are the environment or conditions in which an action has occurred.

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 when rushing to complete 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 early stage.

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 for the other, 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 understand the whole story or to find the deeper root causes. Do not limit your investigation to just one method.

The three case examples that follow are of the thought process using both investigation methods. Please note, although taken from real case scenarios, some details are fictional. See pages 14, 15, and 16 of this guide.

CASE SAMPLE USING BOTH INVESTIGATION METHODS

CASE NO. 1 — Employment Practices Liability

Plaintiff, a female janitor, alleges that throughout her employment her supervisor created a sexually hostile work environment by showing her sexually explicit pictures of himself and touching her in an uninvited, unwanted, and offensive manner. 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 prevention.
3. Why was nothing done if in fact she did report the incidents?
   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 feeling lonely and abused his authority.
5. Why did the manager not know about the supervisor's actions?
   The manager works at headquarters, while the supervisor is at an off-site field location.

Continue 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 re-evaluate 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 the Human Resources (HR) Division if the employee fears the supervisor.
- ⇒ Department managers are not seen often at field locations and field locations are secluded from headquarters.

Solution

Each of the issues described above require a corrective action.

CASE SAMPLE USING BOTH INVESTIGATION METHODS

Case No. 2 —Automobile Liability

This is an Automobile Liability case where, 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., on a dry and clear day. Two employees were traveling in a County-owned truck to a County training, when the driver attempted to make a lane change from the number 1 lane to the number 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 his motorcycle and was consequently ran over and killed by a semi truck and trailer that were traveling on the number 3 lane.

5-Whys

1. Why did this happen?
   The County driver did not see the motorcyclist before changing lanes.
2. Why did the County driver not see the motorcyclist?
   He was only looking for cars on 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 the County driver not check for motorcyclist and his blind spot?
   The County driver was not trained to do so and was unfamiliar with the truck.
4. Why was the County driver unfamiliar with the truck?
   He only drives when needed to attend training; therefore, rarely drives the truck.
5. Why was the motorcycle so close to the truck?
   The motorcyclist was splitting lanes and it was later found that he was not licensed to drive a motorcycle (did not have M1 License).

Continue asking questions…….

People vs. Systems

People

Look at human error in this case:

- ⇒ County driver did not look at his blind spot before making a lane change.
- ⇒ County driver was not aware of the motorcyclist before making a lane change.
- ⇒ County driver had three vehicle accidents in the last two years and had a suspended Driver's License.
- ⇒ Motorcyclist was splitting lanes in an unsafe manner based on the speed of traffic.
- ⇒ Motorcyclist was not licensed to drive a motorcycle.

Systems

- ⇒ Department did not train or orient employees on different vehicle types, i.e., trucks with utility beds and their different sizes, blind spots, etc.
- ⇒ Department did not check employee's Driver's License status record on a regular basis to make sure it was valid.
- ⇒ Department does not have a defensive driver training for employees when hired, nor refreshers.
- ⇒ Department does not conduct a Department of Motor Vehicles' Driver's License status check on new employees—at the time of hire, nor it periodically checks to ensure existing employees have a valid Driver's License.
- ⇒ Department does not have any policies or procedures in place regarding what to do after a vehicle accident. For example, what County forms to complete or who to call.

Solution

Each of the issues described above require a corrective action.

CASE SAMPLE USING BOTH INVESTIGATION METHODS

Case No. 3 — General Liability

This is a General Liability accident wherein, on September 23, 2007, Plaintiff, age 51, 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?
   Department does not have a method to inspect sidewalks and assumed property belonged to the City of Los Angeles (City).
4. Why was it assumed it was the City's property?
   For years no one questioned it and it was assumed to belong to the City.
5. Why was the information not confirmed?
   Managers were not concerned about the issue because they have never had this type of problem before, and the issue has never been brought-up or discussed in the Department.

Continue asking questions……

People vs. Systems

People

Look at human error in this case:

- ⇒ The plaintiff did not watch were she was walking.
- ⇒ 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 exists between Departments on what to do with broken and raised sidewalks. This Department did not know how to be proactive in dealing with damaged sidewalks. There was no Countywide communication or applicability.
- ⇒ Department had no formal method of inspection, repair, nor tracking of damaged sidewalks.
- ⇒ Department did not have confirmed liability as to whose responsibility it was to maintain the sidewalk— 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 described above 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 in place.
- Implementing permanent hazard controls when reasonably practicable.

CONTROLS

The best approach 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.).

MONITORING

MANAGING

MODIFYING

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 on sexual harassment prevention.

Specific

Train all line supervisors and managers in two phases, for example:

- sexual harassment prevention for supervisors by January 2018.
- sexual harassment prevention for managers by March 2018.

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 measureable, 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 the responsible party's follow-up activities.

ATTAINABLE

This stresses the importance of the corrective action to be realistic and attainable. It is ineffective when a corrective action plan stretches a Department's resources or does not include 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 funding from 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.

SMART 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 the 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; the corrective action is given a target date and a commitment to complete. Consider basing timelines on frequency of exposure, severity, 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 quarters, 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 corrective action process is the following:

- Do not over commit. Piecemeal the corrective action steps and be detailed in each process by assigning deadlines. 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 staff to be accountable for the corrective actions.
- Assign a monitor to evaluate and re-evaluate corrective actions to ensure if they are effective, or not.
- Prepare for failure. If corrective action "Plan A" does not work, have an alternative "Plan B" ready.

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 it is 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 of procedures)

RESOURCES WITHIN CEO RISK MANAGEMENT BRANCH
FOR DEPARTMENTAL CAP AND SCAP DEVELOPMENT

Risk Management Inspector General
RMIG@ceo.lacounty.gov
(213) 738-2194

Loss Control and Prevention
(213) 738-2269

CEO Risk Management Branch website
https://riskmanagement.lacounty.gov/

CHECKLIST

THRESHOLD

The CAP is based on tort indemnity settlement amounts above $100,000. However, the preparation of the SCAP should be concurrent with the CAP process, as the SCAP is a redacted and non-confidential version of the CAP.

DEPARTMENTS' INPUT AND ACTIONS

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

- ☐ **The Department receives monthly open/close liability claim reports. These reports are organized by General Liability (GL), Automobile Liability (AL), and Medical Malpractice (MM).**
- ☐ **The Department receives an email from County Counsel requesting investigation, documents, and policies and procedures in regards to the claim.**
- ☐ **The Department attends roundtable meetings with County Counsel, third party administrators, and CEO's Liability Claims Unit and/or RMIG. The roundtable provides additional information and discussion on the claim.**
- ☐ **The Department receives Case Management Reports from County Counsel.**
- ☐ **The Department receives Litigation Management Updates from County Counsel.**

PROCESS

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

- ☐ **Gather information from subject matter experts of affected sections. Ask the right questions and serve as the hub for information.**
- ☐ **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.**
- ☐ **Develop corrective actions and assign responsible parties to complete the actions.**
- ☐ **Submit the CAP to RMIG for approval. If changes need to be made based on RMIG's review and discussion, edit and resubmit the CAP to RMIG for approval.**
- ☐ **Submit the original CAP form to County Counsel after RMIG's approval. After County Counsel receives the CAP, the Claims Board will review and approve. After Claims Board approval, the Board will review and conduct final approval. At each step, if either the Claims Board or Board requires changes to the CAP, the Department must 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.**

CHECKLIST

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** – Upon notification of a tentative settlement in excess of $100,000, RMIG will review the claim and pose questions to the Department, including those that reflect root cause analysis to be addressed in the CAP and SCAP. Departments will have **30** business days from County Counsel or Third-Party Administrator (TPA) notification of a tentative settlement to provide RMIG with a draft CAP and SCAP for review, which incorporates the root cause analysis questions, as well as Department corrective actions.

☐ **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 Departments that need assistance in developing corrective actions and CAPs.
- Reviewing and approving CAPs.
- Providing resources to assist with the completion of CAPs.
- Requesting CAPs following adverse jury verdicts, to be submitted within 45 days of the request.

CHECKLIST

THRESHOLD

The SCAP is a public document (non-confidential) based on tort indemnity settlements in excess of $100,000.

DEPARTMENTS' INPUT AND ACTIONS

The following is a list of events that take place prior to the SCAP process:

1. **The Department receives monthly open/close liability claim reports. These reports are organized by General Liability (GL), Automobile Liability (AL), and Medical Malpractice (MM).**
2. **The Department receives an email from County Counsel requesting investigation, documents, and policies and procedures in regards to the claim.**
3. **The Department attends roundtable meetings with County Counsel, third party administrators, and CEO's Liability Claims Unit and/or RMIG. The roundtable provides additional information and discussion on the claim.**
4. **The Department receives Case Management Reports from County Counsel.**
5. **The Department receives Litigation Management Updates from County Counsel.**

PROCESS

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

Gather information from subject matter experts of affected sections. Ask the right questions and serve as the hub for information.

- ☐ **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.**
- ☐ **Develop corrective actions and assign responsible parties to complete the actions.**
- ☐ **If needed, request assistance anytime during the process but before RMIG's approval and signature.**
- ☐ **Submit the SCAP to RMIG for approval and signature. If changes need to be made based on RMIG's review and discussion, edit and resubmit the SCAP to RMIG for final signature.**
- ☐ **Submit the original SCAP to County Counsel after RMIG's approval and signature. After County Counsel receives the SCAP, the Claims Board will review and do final approval.**
- ☐ **Monitor the corrective actions to ensure they are effective and completed. If the corrective actions do not solve the problem, re-evaluate the situation.**

CHECKLIST

DOCUMENTS

The following is a list of documents the Department will need to complete the SCAP process and conduct an analysis on the data:

☐ **SCAP Template** – Upon notification of a tentative settlement in excess of $100,000, RMIG will review the claim and pose questions to the Department, including those that reflect root cause analysis to be addressed in the CAP and SCAP. Departments will have **30** business days from County Counsel or Third-Party Administrator (TPA) notification of a tentative settlement to provide RMIG with a draft CAP and SCAP for review, which incorporates the root cause analysis questions, as well as Department corrective actions.

☐ **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 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 Departments that need assistance in developing corrective actions and SCAPs.
- Reviewing and approving SCAPs.
- Providing resources to assist with the completion of SCAPs.
- Requesting SCAPs following adverse jury verdicts, to be submitted within 45 days of the request.

CHECKLIST

THRESHOLD

The CWCAP is based on any settlement amount.

DEPARTMENTS' INPUT AND ACTIONS

The following item starts the process of the CWCAP:

☐ **Determine if the Department's SCAP corrective actions are applicable to other divisions within that Department (system-wide) or to other County Departments (Countywide). If so, the Department checks the box on the SCAP to signify that it has potential applicability beyond the Department.**

PROCESS

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

☐ Validate the Department's information pertaining to system-wide and/or Countywide applicability. Determine if there are SCAPs from other Departments with similar facts and applicability that should be incorporated in the CWCAP.

☐ Assist and coordinate Executive Management or key Departments such as Auditor-Controller, CEO, or DHR, with details on the applicable SCAPs.

☐ 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:

☐ **CWCAP** – Developed by Executive Management, Departments, and CEO.

Your comments on this guide are welcome.

If you have any questions or would like to request any forms or related corrective action plan information, please contact:

Risk Management Inspector General
Chief Executive Office—Risk Management Branch
County of Los Angeles
(213) 738-2194
RMIG@ceo.lacounty.gov

This guide is also available on the
Chief Executive Office—Risk Management Branch website, at:

https://riskmanagement.lacounty.gov/

DOCUMENT CHANGE RECORD		
REVISION	**EFFECTIVE DATE**	**DESCRIPTION OF CHANGES**
Release 1.0	October 2005	Initial Release
Release 2.0	September 2007	Update
Release 3.0	November 2007	Update
Release 4.0	April 2012	Second Release
Release 5.0	August 2016	Third Release
Release 6.0	April 2018	Update

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3333 WILSHIRE BOULEVARD, SUITE 820
LOS ANGELES, CA 90010
(213) 351-5346
(213) 252-0404 FAX
https://riskmanagement.lacounty.gov/