ORDINANCE NO. 04272

BOARD OF SUPERVISORS, COUNTY OF SAN MATEO,
STATE OF CALIFORNIA

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AN ORDINANCE ADDING CHAPTER 2.207 TO TITLE 2 OF THE SAN MATEO COUNTY ORDINANCE CODE PROVIDING FOR THE REPORTING OF ADVERSE EVENTS IN THE PROVISION OF HEALTH CARE THAT OCCUR IN COUNTY OPERATED HEALTH CARE FACILITIES

The Board of Supervisors of the County of San Mateo, State of California, **ORDAINS** as follows:

SECTION 1. Chapter 2.207, Sections 2.207.010 to 2.207.070, is hereby added to Title 2 of the San Mateo County Ordinance Code as follows:

Chapter 2.207 REPORTING OF ADVERSE EVENTS IN THE PROVISION OF HEALTH CARE THAT OCCUR IN COUNTY OPERATED HEALTH CARE FACILITIES

Section 2.207.010. PURPOSE

The County of San Mateo has a paramount interest in protecting the health and safety of the public and in providing the highest standard of health care. To further this interest, employees of the Health Services Agency, the San Mateo Medical Center and clinics, and contractors who perform health care services at County operated health care facilities should be encouraged to report to their supervisor adverse events in health care facilities operated by the County. Members of the public also should be encouraged to report adverse events occurring in the hospital or its clinics to San Mateo Medical Center's Quality Management and to report adverse events occurring at the Public Health labs or clinics to the Director of the Health Services Agency.

This ordinance describes the kinds of adverse events that should be reported and sets forth the reporting and investigative process to be followed. These reports and investigations shall be done in such a manner as to not violate state or federal laws regulating the privacy of protected health care information and are in addition to any other statutory reporting requirements.

This ordinance also protects all those employees who make such reports from retaliation from reporting the event or providing information about the event.

Section 2.207.020. DEFINITION AND DESCRIPTION OF ADVERSE EVENTS

An adverse event is an unintended situation that arises from an error in medical diagnosis, procedure, equipment, product, medication or other patient care that

results in death or serious injury. Serious injury includes loss of limb or function. Examples of such unintended situations include, but are not limited to, those events listed below which have been derived from the National Quality Forum's List of 27 Serious Reportable Events.

(a) Surgical Events such as, but not limited to, surgery performed on the wrong person or body part, performing the wrong surgical procedure, leaving foreign objects in patients, and death during or immediately after surgery.

(b) Product Or Device Events such as, but not limited to, deaths or serious injuries associated with malfunctioning devices, contaminated drugs, devices or biologics, and intravascular air embolism**.**

(c) Patient Protection Events such as, but not limited to, switched babies, patient disappearances where the patient lacks decision-making capacity, and suicides and attempted suicides of patients while admitted**.**

(d) Care Management Events such as, but not limited to, patient deaths or serious injuries resulting from medication errors, administration of incompatible blood or blood-products, labor or delivery, hypoglycemia, severe ulcers acquired after admission, and spinal manipulation therapy**.**

(e) Environmental Events such as, but not limited to, patient deaths or serious injuries resulting from electrical shock, gas line errors, burns, falls, and the use of restraints or bedrails.

(f) Criminal Events such as, but not limited to, impersonation of physicians or other providers, patient abductions, sexual assaults on patients, and patient or staff deaths or significant injuries due to physical assaults.

Section 2.207.030 REPORTING OF ADVERSE EVENTS REGARDING THE PROVISION OF HEALTH CARE

Reporting of adverse events regarding the provisions of health care shall be reported as follows:

(a) Reporting by Employees. Any employee of the Health Services Agency, the San Mateo Medical Center and clinics who believes, observes or otherwise becomes aware of an adverse event involving the provision of health care that has occurred at a County operated health care facility must immediately report the event to his/her supervisor/manager.

(b) Reporting by Contractors. Any contractor who performs health care services at County operated health care facilities, who believes, observes or otherwise becomes aware of an adverse event involving the provision of health care that has occurred at a County operated health care facility must immediately report the

event to the applicable manager.

(c) Reporting by Members of The Public. A patient, healthcare professional (who is not an employee or contractor), or any other member of the public who believes that an adverse event involving the provision of health care has occurred at a County operated health care facility, should be encouraged to report the event to staff. Staff should then immediately report the incident to his/her manager/supervisor. For those incidents that occur in the hospital or its clinics the reports should be directed to San Mateo Medical Center's Quality Management. For those occurring at the Public Health labs or clinics, the reports should be directed to the Director of the Health Services Agency.

Section 2.207.040. PROCESS TO BE USED AFTER RECEIVING A REPORT MADE PURSUANT TO SECTION 2.207.030.

Upon receipt of a report made pursuant to section 2.207,030, the recipient manager/supervisor shall promptly report the matter to his or her Department Head.

The Department Head or his/her designee, within twenty four hours of receiving notice of the matter, shall report the event to the County Manager. The County Manager shall notify the County Counsel who, in consultation with the County Manager, shall provide the Board of Supervisors with a summary of the event, as appropriate.

For all adverse events occurring at the San Mateo Medical Center, the Department Head, in consultation with the County Manager, County Counsel, and the President of the Hospital Board of Trustees, shall determine if the Hospital Board shall convene a special meeting to address the incident. The Hospital Board of Trustees may take any action it deems necessary, including, where appropriate, a recommendation to the Board of Supervisors.

All adverse events shall immediately be reported and disclosed to the patient or patient's legal representative. In addition, the results of any investigation pursuant to Section 2.207.050 below shall also be disclosed to the patient or patient's legal representative.

These reports shall be done in such a manner as to not violate state or federal laws regulating the privacy of protected health care information.

Section 2.207.050. INVESTIGATION

Upon notification of an adverse event, the Department Head, or his/her designee, shall promptly refer the matter to the appropriate quality/safety individual, and/or interdisciplinary team, which shall, if appropriate, promptly plan and conduct an investigation. Depending on the nature of the incident, the investigation may involve departmental management, Employee Relations, the Coroner, and/or

appropriate licensing and law enforcement agencies.

The investigation shall be conducted in accordance with all existing policies, including the Integrated Patient Safety Plan for those facilities covered by such plan. The investigation will determine the existence of system-based causes of adverse events. The investigation will include recommendations of potential improvements that would reduce the likelihood of similar adverse events.

Throughout the investigative process, all involved parties will treat the report and related information, including but not limited to information gathered and prepared in the course of the investigation of the incident, as confidential unless otherwise necessary to conduct the investigation. Any disclosure of information shall be done in such a manner as to not violate state or federal laws regulating the privacy of protected health care information.

At the conclusion of the investigation, the Department Head will take the necessary steps to address the incident, including any necessary systemic changes to minimize or prevent reoccurrence of any such incident. The Department Head shall also notify the person who filed the report that investigation has been completed.

Section 2.207.060. SEMI-ANNUAL REPORT OF ACTIONS TAKEN

The Chief Executive Officer of the San Mateo Medical Center and the Director of the Health Services Agency shall submit a semi-annual summary report to the Board of Supervisors delineating the types of reports that have been made under this ordinance as well as the implementation of any significant new program, policy or facility improvements that have been made as a result of such reports.

Section 2.207.070. NO RETALIATION

Any retaliation or reprisal by any County officer or employee against any complainant or informant for reporting an adverse event is strictly prohibited and any act of retaliation or reprisal is subject to appropriate disciplinary action, which may include dismissal; provided, however, if it is determined that a complaint was filed by a County employee in bad faith, said employee may be subject to appropriate disciplinary action. This prohibition against retaliation is in addition to the protections contained in Labor Code section 1102.5, and any amendment thereto.

SECTION 2. This Ordinance shall be effective thirty (30) days from the passage date thereof.

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