

# **Risk Management Guide**

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## **Introduction**

The Professional Risk Management (PRM) Department was established to administer the University of Colorado Professional Liability Program. The primary responsibility of the PRM Department is to reduce and, if possible, eliminate the causes and frequency of claims and lawsuits involving the University of Colorado, and University of Colorado Hospital (UCH) faculty and staff and thereby minimize financial loss to the program. As one can imagine, this is a complex, interdisciplinary task. Cooperation and support are essential for a successful risk management program.

This guide will provide a handy reference to the many issues associated with the program. The PRM Office staff is available for consultation on any of the issues in this guide and may be contacted between 8 a.m. and 5 p.m., Monday through Friday, at 303-724- 7475. During off hours, a message can be left on the department's voicemail or the administrator on call is available to assist by calling the hospital operator.

**Risk Management:** Professional Risk Management is a program designed to reduce malpractice claims while maintaining the provision of high quality patient care. Unlike defensive medicine, risk management is not just a set of strategies for preventing claims. Instead, it works in the best interest of patients and providers. Providers are all healthcare staff including physicians, nurses, technicians and hospital staff. Risk management stresses good rapport and communication between provider and patient and among the various providers. PRM encourages the development of careful documentation and communication skills.

**Communication:** An open line of communication between the patient and healthcare provider is one of the most important skills to incorporate as part of one's professional practice and found to be a key factor in reducing lawsuits. Studies have shown that patients who have good rapport with their physicians file fewer lawsuits. (People generally do not sue friends or those whom they trust and respect.) Patients have a right to as much information about their health care as they desire. Residents should encourage information sharing between themselves and their patients.

When there is a less than optimal outcome, or if a patient suffers an iatrogenic injury, his/her need for physician/provider support is often at its highest. Facing these situations openly and honestly, with an extra dose of "bedside manner" and courteous treatment of family members and friends, may improve a patient's perception of the quality of care. Developing positive patient relations is good medicine and good business.

## **Informed Consent**

**Necessary:** An informed consent is necessary (except in emergency situations-see below) before performing any procedures or treatment other than simple or common procedures wherein the risk is low and commonly understood. In order to give a valid consent, a patient must freely consent to the treatment or procedure, having been given enough information explained in lay terms to make a knowledgeable decision whether to undergo the treatment or procedure. It is the treating physician's duty and responsibility to obtain the consent personally; it may not be delegated to non-physicians.

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**What to Include:** The informed consent discussion should include the following five sections: (1) nature, purpose and benefits of the procedure; (2) risks of the procedure; (3) alternate treatments (if any); (4) benefits and risks of alternative treatments; and (5) possible outcome or risks if no treatment is given. While it is not possible to list every risk of every surgical procedure, the physician should discuss the statistically significant four or five most likely potential complications including common potential risks such as infections, blood loss and scarring. Additionally, any serious risk of the procedure, no matter how uncommon, such as death, permanent disfigurement, or brain damage should be discussed. Detailed information about the informed consent process also is available in the PRM Office. The above information should be presented to the patient in a caring, but objective, manner. A consent that is obtained through exaggeration, misrepresentation, intimidation or the like is invalid and may be the basis for a medical malpractice claim.

**Documentation:** It is unnecessary to list each risk in the documentation of the discussion. One way to document is to enter a notation in the chart stating “nature, alternatives and risks of procedure discussed and patient understands and agrees to procedure.” Any particularly important risk that warrants discussion should be mentioned, such as “explained risks, with emphasis on ....” If an interpreter is used during the discussion, the interpreter’s name should be indicated clearly in the charting note and on the consent form.

**Forms:** The hospital consent form must always be completed to verify that an informed consent has been obtained. Informed Consent is a process of communication with a patient regarding the risk and benefit of a planned procedure. The form is required to document the procedure. The form alone can never be considered an informed consent. Signature of a witness, other than the physician, is only necessary during telephone and verbal consents.

**Emergency:** An informed consent is not necessary in a **medical emergency** when (1) the patient is not able or competent to give consent; (2) has not previously withheld consent for the planned procedure; and (3) a relative, guardian or other authorized person or agent is unavailable to give consent. The chart notes should clearly document the situation. A *Certification of Emergency* form must be signed by the physician and the administrator on call notified (see Administrative Policy I-3). (NOTE: This does not apply to the Emergency Department.)

**Refusing Treatment:** A competent adult patient has the right to refuse treatment. If the Resident feels the treatment is essential to prevent serious deterioration or death, they can recommend that involved family members or friends speak to the patient regarding the benefits of the treatment. If the Resident feels that the patient is confused about the recommended treatment, a psychiatric consult may be requested. However, it must be emphasized that a competent adult patient can legally refuse treatment, regardless of the opinions of family, friends, or the healthcare team. If after consent is requested, and the patient refuses the recommended course of treatment, documentation is critical. It is important to specifically note in the medical record the patient’s understanding of the benefits of the recommended treatment and the risk/results of refusing treatment. (Also see **Informed Consent Policy, UCH Administrative Policy I-3, for more detailed information; when at UC Denver affiliate institutions, reference their specific policies.**)

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## **Who May Consent**

**Adults:** An adult (18 years of age or older) may consent to treatment (exception: Medicaid requirement for sterilization is 21 years of age). The person must be mentally competent and must not have recently received anesthetic or sedation. A mentally challenged person is not necessarily incompetent, but an individual should be able to understand the information. This is a judgment made in good faith by the physician. If unsure about a person's competency level, obtain a second opinion and document the decision process in the medical record.

**Minors:** A minor (under 18 years of age) may consent to treatment in any of the situations described below, except sterilization:

1. Emancipated (15 years of age or older)
2. Legally married
3. Seeking pregnancy testing, birth control or abortion
4. Treatment of EtOH and drug abuse (unless intoxicated)
5. Treatment of venereal disease
6. Mental health services (15 years of age or older)
7. Treatment of HIV
8. Abuse
9. Children of minors
10. On active duty with the U.S. Armed Forces

## **Methods of Obtaining Consent**

**Written Consent:** Written consent on the appropriate form should be obtained whenever possible. However, if it is not possible to obtain written informed consent, consent may be obtained by one of the following less satisfactory methods.

**Verbal Consent:** Although verbal consent is valid, it may be difficult to prove. This is the reason that written consent should be obtained whenever possible. Verbal consents should be witnessed by two individuals (the physician and one other person) and documented in the medical record. Immediate steps should be taken to procure confirmation in writing.

**Telephone Consent:** Consent by telephone must be witnessed and documented in the medical record indicating the exact time and nature of the consent given. Telephone consents must be witnessed by two individuals (the physician and one other person). Immediate steps should be taken to procure confirmation in writing.

## **Consent Policies**

**Role of Non-Physicians:** If a hospital employee finds that a patient does not understand the pertinent elements of the scheduled procedure, or the patient indicates a change of mind, the physician must be notified immediately.

**Copies:** While the original consent form should always be kept in the medical record, a legible copy is adequate.

**Duration:** A consent is considered valid and in effect until either (1) the patient has revoked the consent (which may be done at any time); (2) 30 days have elapsed; or (3) there are changed circumstances which would significantly affect the nature of or risks of the procedure. For

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example, when a patient has been admitted for a specific course of treatment including a specific operation, but while studying the patient several days elapse and the anticipated operation/procedure changes, the physician should obtain a new informed consent.

**Abbreviations:** It is in the hospital's best interest to avoid the use of abbreviations on consent forms. Only abbreviations that are considered common knowledge to both the patient and physician may be used.

**Medications and the Consent Process:** For a consent to be valid, it must be obtained from a competent patient. Competency is defined to mean an ability to understand the nature and consequences of what one is asked to consent. If medication was given prior to the consent process and if such medication might affect a patient's ability to comprehend the situation, then it becomes the physician's responsibility to determine competency to consent.

**Telephone Consent:** Consent for treatment should be obtained by telephone only if the person(s) having legal capacity to consent for the patient is not otherwise available. If a physician obtains a consent by telephone, a hospital staff witness should listen in on the telephone to the consenting process. The physician must alert the patient/representative that a third party is on the line. The verification by the witness must be documented on the consent form.

**Patient Unable to Sign:** In the event a patient is physically unable to write his name, his mark must be obtained. This is done by a UCH staff member first printing the patient's name in full and then having the person place his/her 'X' beneath it. Two persons should witness the patient place his or her mark on the consent.

## **Malpractice Insurance Coverage**

Professional malpractice refers to an event where a patient is injured as a result of medical negligence. Specifically, malpractice is present when (1) there is an act or failure to act which is below the "standard of care," and (2) this act or failure to act results in a personal injury to the patient. The PRM staff seeks to identify such situations when they arise and take early intervention to avoid the filing of a lawsuit. However, if a suit is filed and the Resident is involved in the case, he/she will be covered by the University's self-insurance program in accordance with the following sections.

**Self-Insurance Program:** Professional liability "malpractice" coverage for Residents is provided through the University of Colorado's Self-Insurance and Risk Management Trust. The University of Colorado became self-insured under the Trust for Medical Malpractice June 23, 1976. To administer the medical self-insurance trust fund, the University has established a Professional Risk Management Program. Coverage is provided on an occurrence basis. Therefore, Residents are covered for acts within the course and scope of employment even if a claim or lawsuit is brought for that occurrence after leaving the employment of the University. To ensure protection when on rotation at another hospital, the University enters into affiliation service agreements with these facilities.

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It is recommended that Residents always wear the UC ID badge, identify themselves as an employee of the UC and sign, as such, in the medical record while rendering care to patients at other institutions. **Moonlighting, by definition, is not an approved activity and deemed to be outside the course and scope of University of Colorado employment.** Contact the PRM Department at 303-724-7475 for questions on coverage.

## **Attorneys**

**Contact Professional Risk Management:** Do not enter into conversations with attorneys regarding patient care matters without first checking with the Professional Risk Management Office. Revealing sensitive patient care information to unknown individuals — regardless of whom they say they are — can constitute a breach of patient confidentiality. Furthermore, answering questions from a patient’s attorney out of context and without the guidance of well-informed and capable legal counsel can be against the Resident’s interest and that of UCD. Check with the PRM Office to determine whether the attorney is an appointed University employee or agent.

On the other hand, **once the PRM Office has confirmed that an attorney is a University agent, complete cooperation is very important.** Since the Resident’s attorney will need help to understand the often complex issues surrounding the medical

care in question, a close attorney-client working relationship is essential. Never hesitate to reveal circumstances that may seem negative (when in a private conference with a University attorney only), for only with a complete understanding of the facts can legal counsel effectively defend the Resident.

**Depositions:** If contacted regarding a deposition as a result of a University assignment, the Resident should notify the PRM Office as soon as possible. Most depositions can be conducted at a convenient time and place. If appropriate, an attorney will be available to brief the Resident on testifying or will accompany the Resident to the deposition to protect his/her interests and those of the University.

A deposition is one of several means provided by Colorado law for taking testimony under oath. Depositions serve several purposes. Without using expensive court time, they allow the attorneys to “discover” knowledge regarding a case. They commit testimony given under oath. Depositions give the attorneys for both sides an opportunity to evaluate the impression the Resident would make on a jury. Finally, they preserve the testimony if the Resident cannot be present at a trial.

**Expert Witness Testimony:** If a Resident is not an involved witness or a defendant in a case and is asked to testify, it will likely be as an expert witness. Serving as an expert witness in a case is strictly voluntary. The Resident is entitled to an expert witness fee if asked to provide an expert opinion regarding a patient’s care in which, they Resident as no involvement. Fees should be negotiated with the attorney according to what the Resident’s time is worth. When asked to testify as an expert witness for a University lawsuit, fees must be approved by University counsel and the PRM Office. The mechanism for payment is also arranged through these offices.

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When considering testifying as an expert, it is the Resident's professional responsibility to ensure that there is no conflict of interest, and to determine that the Resident's background gives adequate qualification. Before considering rendering an opinion as an expert witness in a case, the Resident should verify that it does not adversely affect another University of Colorado employee.

## **Legal Documents**

**Subpoena:** A subpoena is an order of a court or an authorized agency commanding the person subpoenaed to appear as a witness.

**Subpoena Duces Tecum:** A subpoena duces tecum requires the person subpoenaed to produce records or documents officially under his/her control at a specified time and place. If the subpoena duces tecum is for the patient's medical record, direct the server to the Medical Records Department.

**Notice of Claim:** Within 182 days after the discovery of an injury attributable to a public entity and employee, a written notice must be filed which states the following: the name

and address of the claimant and that of his/her attorney, if any; a concise statement of the factual basis of the claim, including the date, time, place and circumstances of the act, omission, or event complained of; the name and address of any public employee involved, if known; a concise statement of the nature and extent of the injury; and a statement of the amount of monetary damages sought. A "Notice of Claim" must be filed with the University of Colorado when one of its employees is involved. The PRM Office will investigate all Notices of Claim involving patient care by UC physicians and other employees.

**Summons and Complaint:** A Summons and Complaint is a notice to a defendant and the initial pleading by a plaintiff in a civil court action. The complaint details the various allegations of misconduct by the defendant and the request for monetary compensation.

**Notify Professional Risk Management:** Upon receipt of any legal correspondence from patients, attorneys or courts, or Department of Regulatory Agencies (DORA); notify the Office of University Counsel, 303-315-6617, or Professional Risk Management, 303-724-RISK (7475), immediately. As certain legal documents must be responded to within a statutory time limit, our immediate receipt of legal correspondence is imperative. Failure to respond on time may result in default judgments, the issuance of a bench warrant, or other sanctions entered against the Resident and/or the University. Please record the exact date and time of receiving a document and bring the original to the Office of University Counsel, School of Medicine, Room 1660.

**Who Accepts:** Before accepting a legal document, **determine whether it names a Resident specifically** or whether it names another individual and/or UC or University of Colorado Hospital. If the legal document names the individual Resident specifically, the Resident must accept it. If the legal document names an individual in the department, accept it only if previously authorized to do so. If someone other than the person named accepts a legal document, it then becomes the responsibility of the acceptor to promptly deliver the legal

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document. It is important to emphasize that no employee should accept a legal document unless specifically authorized to do so or the individual is specifically named.

## **Withholding/Withdrawing Life Support**

University of Colorado Hospital has a policy for withholding or withdrawing life support measures which is available in the *Administrative Policy and Procedures Manual*. (Patients treated at an affiliated hospital are governed by the affiliated hospital's policy.) Every patient has the right to make informed decisions regarding his/her medical treatment, including the withholding or withdrawal of life support. These options should be discussed with each patient who may require life support as a component of his/her treatment. In the case of incompetent patients, other sources of authority for treatment decisions include living wills, durable powers of attorney, court-appointed guardians and next of kin.

Addressing the issue of life support with patients and families in advance of the need for life support will help avoid confusion and difficult ethical decisions when the need for life support arises. Healthcare providers who disagree with a patient's or family's decision regarding life support should transfer the patient or arrange for care by another provider.

More information is available in the *Administrative Policy and Procedure Manual*. Also, the hospital chaplain can assist in addressing issues of life support with patients. Another source of assistance for providers faced with life support decisions is the Hospital Ethics Committee.

**Colorado Medical Treatment Decision Act:** The Colorado Medical Treatment Decision Act allows competent adult patients to declare in writing that their physician withhold or withdraw life sustaining procedures 'in the event of a terminal condition.' The written declaration, called a "Declaration as to Medical or Surgical Treatment," should follow the statutorily prescribed form and wording, and be properly executed. Consult the PRM Office or Office of University Counsel for more information or approval of documents.

**Brain Death:** In general, when an individual is pronounced dead by determining the individual has sustained an irreversible cessation of all functions of the entire brain, including the brainstem, and that determination has been independently confirmed by a second physician, life support should be discontinued. Consultation with the appropriate attending physician is required. **The pronouncement of brain death is a medical act that does not require the consent of a patient's relative, guardian or other legally authorized person or agency.**

## **Documentation**

**Avoiding Liability:** The patient's medical record almost always becomes the primary source of evidence throughout a malpractice action. As the memories of the plaintiff and defendants can be faulty, selective, or both, courts must rely upon the medical record as the primary account of what actually transpired. Therefore, it is very important to **document all relevant and appropriate information regarding a patient's health care in the chart**. Further, it should be done legibly. A plaintiff's attorney may be convinced to take on even the most marginal of cases if the medical records are incomplete and/or poorly written.

**What to Document:** Facts; dates and times; patient's condition; treatment recommended; treatment provided; noncompliance with recommended treatment, prescriptions; appointments;

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“no shows”; all prescriptions and refills; evidence of informed consent; sources of information, if other than the patient; rationale for any unusual type of care; complications, mishaps, or unusual occurrences; significant discussions with patient or family; worries or concerns expressed by patient or family; brief record of complaints about the quality of care from the patient or family and response; responses to entries by others that require action by the provider.

Reasons the patient needs to be in an acute care hospital; reasons for transfer from one facility to another such as availability of services; an accurate and complete discharge assessment after discussion with discharge planning; comments on test results which indicate the need for continued care or changes in treatment plans; the reason for admission for a procedure usually done as an outpatient; the severity of the patient’s condition and limits of activity; specific diagnosis (e.g., rather than anemia, define the type of anemia); tests pertinent to diagnosis update and completeness; differential diagnosis at time of admission (rule-outs); pending lab results and the reason they are needed for continued hospitalization; attempts at outpatient treatment prior to admission and reason for admission thereafter; facts that make a patient’s discharge or transfer unacceptable.

**What NOT to Document:** Risk prevention activities; anything about an occurrence report; matters which have legal implications but have no value to patient care; an entry requiring action by a Resident or other staff unless they are certain it will take place; disagreement with another entry when there is a reasonable explanation; opinions regarding the actions of other staff; statements blaming the hospital or economic factors; statements regarding care rendered by other healthcare providers; disapproval or a negative value judgment of the patient; self-serving statements; changes or additions to previous entries after a claim is filed.

Beliefs that the patient should not be in the hospital; comments about DRGs, PROs, or administration, utilization, or discharge planning staff; unjustified social or administrative reasons for continued stay; patient’s reluctance to be discharged unless accompanied by justifiable reasons and plans to resolve problems.

**Increasing Reimbursement:** Lack of documentation or poor documentation can cause denial of payments to the hospital in many instances. Good documentation, which reveals the appropriateness of admission and the need for continued acute stay, not only increases the likelihood of reimbursement, it facilitates communication between providers and increases the quality of care.

**Changes to Entries:** Never change an entry in the medical record. Doing so is a sure way to destroy the defense of an otherwise defensible case. It also may be fraud. By the time a claim is filed, a plaintiff’s attorney most likely will have a copy of the record.

**Residents may make corrections in everyday charting by drawing a single line through an erroneous entry, thereby leaving the entry legible.** Date and sign the correction in the margin. If needed, add an explanation of the correct entry in the next available area. **Never use correcting fluid or completely mark over an entry. In the electronic medical record (EMR), Residents may make corrections in everyday charting by composing an addendum.** Never remove information or pages from the chart once they have become part of the official record.



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**Written Orders:** Good documentation is the most valuable tool in preventing and minimizing liability; it requires that a Resident's request for ancillary services, such as x-ray and lab, always be in writing or ordered electronically in the EMR. While a telephone call may help expedite an x-ray or lab request, the initial request should be documented by the appropriate mechanism. Not only will this improve the process of obtaining services, but also from a liability standpoint it is always easier to defend an incorrect document than no document.

## **Occurrence Reports**

The *Occurrence Report* is an important communication tool used by the PRM Department. It allows the entire UC Denver staff to provide **confidential notification** of any situation involving injury or potential injury to a patient, or any event that may contribute to liability problems in the future. Reports allow the PRM Department to proceed with **early intervention** by following up on significant reports.

UCH has implemented an online system of reporting Patient Occurrences using a product called Safety Intelligence (SI). Access to this online system is available on most UCH unit computers. Any Medical Staff member who suspects an actual or potential patient occurrence enters a report electronically via SI. In accordance with UCH policy, events are to be reported within 3 days. Events involving great potential or actual risk, or those which are reportable to regulatory agencies are reported immediately via SI and a telephone call to Professional Risk Management at 303-724-RISK (7475). When clinical services are provided at affiliate hospitals, a phone report would be required because the online system pertains to UCH locations only.

When a patient injury has occurred, contact the PRM Department immediately at 303-724-RISK (7475). (Voicemail is utilized during off-business hours to receive reports.)

**Reportable Occurrences:** These include unexpected/unexplained deaths; patients who are away from the hospital without being discharged and without notifying their providers (AWOL); unplanned removal or injury to an organ during surgery; hospital acquired infections or trauma (falls, hit by equipment, etc.); significant adverse drug reaction; medication errors; equipment failures; actions by abusive patients or staff; and any occurrences that cause an angry reaction by patient or family member.

***Occurrence Reports should never be*** used for disciplinary action, photocopied, mentioned or included in the medical record, posted in a public area, discussed with anyone other than PRM staff or their legal representatives. Employee injuries should be reported on an Employee Occurrence Form and sent to the Employee Health Services (Mail Stop B-213).

Visitor injuries should be reported to Security at 720-848-7777 and by filling out the Visitor Occurrence Report on the hub (<http://hub.uch.edu/>) and faxed to 720-848-5501.

**Nosocomial Infections** should also be reported to the Infection Control Department.

## **Interdepartmental Problem/Incident Form**

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Questions often arise regarding when to use an *Interdepartmental Incident Form* as opposed to a *Patient Occurrence Report*. Always report a patient's injury to PRM on the *Patient Occurrence Report*. An *Interdepartmental Incident Form* is appropriate for situations that are potentially harmful in a general way to patients, visitors, employees or the hospital. Frequent or ongoing delays in service, frequent policy violations or any physical hazards are some examples. An *Interdepartmental Incident Form* generally cites system or operational problems and other overall issues affecting quality of care, while an *Occurrence Report* addresses a specific occurrence involving a specific patient or visitor.

The *Interdepartmental Incident Form*, with the problem identified, is forwarded to the involved department(s) for evaluation of the problem and the department's response is then sent to the reporting department. Therefore, it is imperative that it be completed legibly. If the Resident includes his/her name and location, the response will be forwarded personally to them. Data from the forms are intended for presentation to appropriate committees. *Interdepartmental Incident Forms* are available on all nursing units.

## **Patient Problems and Concerns**

**Medical Records and X-Rays:** If patients need a copy of their charts, refer them to Health Information Management at 720-848-1031. If patients desire copies of x-rays, refer them to the Radiology File Room at 720-848-1105. There will be a charge. Charts and x-ray films involving lawsuits are placed in secure storage by custodians upon notification by Professional Risk Management. When outside requests or subpoenas for charts and x-ray files are received on claim records, the custodian should contact PRM before releasing the records. If there is a suggestion of legal action against the University when an outside request is received, notify Professional Risk Management.

**Bills and Charges:** Avoid offering to reduce or eliminate charges or saying that insurance will be accepted as payment in full. If a patient is questioning a charge or desires an explanation of his/her bill, refer him/her to the Patient Services Office at 720-848-8800 for hospital bills and University Physicians, Inc. at 303-493-7000 for physician bills. When a patient resists payment and alleges that the quality of care was below standard, the PRM Office should be notified. A physician has no authority to reduce hospital charges, and most patients do not realize that professional fees and hospital charges are separately generated and charged. Often when a complication in treatment arises, whether it is within the standard of care or not, a provider is tempted to offer a reduction of charges. If professional fees are waived or reduced, it should be made clear that this will not affect hospital charges. Contact Professional Risk Management before making such arrangements.

**Property:** Patients/families should be advised on admission not to keep valuables with them while in the hospital. If necessary, they can be stored in the safe in Admissions. If loss or damage to property of a patient is known or alleged, the circumstances are to be reported to 720-848-7777.

**Complaints:** Patient complaints should be forwarded to the patient representative unless they involve quality of care or potential liability issues. The patient representative also handles

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complaints that require immediate/same day action. **If patients want to file a complaint, do not discourage them.** Direct complaints to the patient representative at 720-848-5277.

**Abusive and Uncooperative Patients:** When a patient is being abusive or uncooperative, contact PRM to help determine the best course of action. **Fully document inappropriate behaviors** and all discussions with the patient regarding them. Especially note the progression of warnings and attempts to safeguard the health and safety of the patient and other patients and staff. Remember not to express value judgments in the medical record; stick to the facts.

## **Reporting Responsibilities**

**Child and Elder Abuse:** Colorado law requires University of Colorado Hospital healthcare personnel to report suspected cases of abuse or neglect of children or dependent adults. The law also prohibits any civil or criminal action against healthcare personnel for fulfilling reporting responsibilities. The possibility of abuse should be considered when any of the following conditions are present: 1) there is no explanation for the injury; several explanations, or the explanation given is not compatible with the patient's age and injury; 2) multiple or recurrent injuries; 3) delay in seeking medical treatment; 4) nonorganic failure to thrive; 5) medical or physical neglect; 6) a child is dead on arrival; 7) severe emotional damage due to the home situation; 8) any suggestion of sexual assault or inappropriate confinement; and/or 9) direct beatings or unexplained bruises or welts. Further, in the case of dependent adults, staff should be suspicious of cuts, freezing, lacerations, punctures, bone fractures, dislocations, sprains, burns, scalding, internal injuries, or overmedication.

If abuse is suspected or case consultation is desired, please refer to Hospital Policy on suspected Child Abuse (P-10) for reporting requirements and consultation services.

**Reportable Deaths to the Coroner:** Government regulations (§ 30-10-606(1), C.R.S.) require the immediate reporting of the following deaths to the coroner for investigation:

- 1) any death within 24 hours of arrival at the hospital;
- 2) from external violence, unexplained cause, or under suspicious circumstances;
- 3) where no physician is in attendance, or where, although in attendance, the physician is unable to certify the cause of death;
- 4) from thermal, chemical, or radiation injury;
- 5) from criminal abortion, including any situation where such abortion may have been self-induced;
- 6) from a disease which may be hazardous or contagious or which may constitute a threat to the health of the general public;
- 7) while in the custody of law enforcement official or while incarcerated in a public institution;
- 8) when the death was sudden and happened to a person who was in good health; *or*
- 9) from an industrial accident.

More information, including explanation and comments on certain types of deaths which have been difficult to evaluate, is available from the PRM Office. To report a coroner's case, call 303-659-1027. If in doubt, call the coroner.

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**Reportable Injuries to Law Enforcement Agencies:** The Emergency Department is responsible for reporting the treatment of certain types of cases to the UC Denver Police Department which will notify the appropriate law enforcement agencies. Identification of such cases is the responsibility of Emergency Department personnel who must notify UC Denver Police Department when such cases appear for treatment. Reporting is not necessary if police accompany the patient to the Emergency Department or if reliable information is available that police were at the scene of the incident/accident.

Types of reportable incidents/accidents include:

1) Suspected cases of child abuse or neglect (must be reported either to county social services or local law enforcement (required by § 12-36-135, C.R.S.).

2) Injuries involving bullet wounds, gunshot wounds, powder burns or any other injuries arising from the discharge of a firearm, or any injury caused by a knife, an ice pick, or any other sharp or pointed instrument which the physician believes to have been intentionally inflicted upon a person, or any other injury which he or she has reason to believe involves a criminal act (required by § 19-3-304, C.R.S.).

Reports should be filed with the police in the jurisdiction where the incident/ accident occurred and the Aurora Police Department. Notify UC Denver Police and they will call the appropriate jurisdiction.

3) Rape: When directed to do so by the responsible physician or **AT THE VICTIM'S REQUEST**, notify the appropriate law enforcement jurisdiction (ex: Denver Police Department or Aurora Police Department).

4) Attempted suicide: When directed to do so by the responsible physician, report to the appropriate law enforcement jurisdiction (ex: Denver Police Department or Aurora Police Department).