[redacted]

Quality Assurance

Created 07/21/2013
Revised 11/01/2023

Purpose

To ensure systematic monitoring and evaluation of [redacted] procedures so that standards of quality are being met. We monitor work carried out in the office for random or systematic errors resulting in a continuous improvement in quality and efficiency.

Policy

It is the policy of [redacted] to regularly monitor and evaluate routine procedures as well as the quality of medical investigator's reports and autopsy reports. The office will participate in internal review procedures as well as external proficiency testing. See **Appendix D** for Quality Assurance/Quality Control worksheets.

Procedures

Medical Investigator and Autopsy Report Review

A full report is prepared by the medical investigator on every jurisdictional case, in accordance with Colorado law, and provides a mechanism for quality assurance on all cases. Cases are formally discussed at the daily morning staff meeting to decide on proper handling of the case and provide educational feedback to correct errors or omissions and improve informational quality; a medical investigator quality assurance form will be completed for all cases discussed. The investigative narrative reports are proofread by the forensic pathologist assigned to the case and any clerical or informational errors highlighted for correction. Suggestions for further investigation, obtaining additions medical records or information from family sources or law enforcement are made at morning meeting and are assigned to the on-duty investigator for follow-up. Final decisions as to full autopsy vs. external examination vs. chart review vs. no jurisdiction assumed will also be made at this time. An effort is made to ensure that decisions and procedures are consistent within a case and among similar cases.

In the majority of cases, full autopsies will be carried out as detailed elsewhere. Dictated reports are corrected using a standard spell-check program at the time of transcription. The report is further proofread by the attending pathologist for medical accuracy. After results of further investigations, histologic, toxicologic, metabolic and other studies are received, the case is then finalized with respect to cause and manner of death. Equivocal cases, particularly those of a homicidal nature, undetermined cause or manner, or those involving unusual medications or drugs of abuse will be discussed at a difficult case conference with another pathologist for final certification. Once again, internal and external consistency in death certification is of paramount importance. Records are kept in the electronic case management system (ECMS) in reference to these conferences. In occasional cases, external review occurs with pathologists at other institutions, and unusual or equivocal toxicology issues may also be reviewed with a forensic toxicologist. Records of these consultations are maintained in the appropriate file, with consultations tracked in the ECMS, and any written consultations stored in the paper case file as well as scanned into the ECMS. Periodically, a summary of the findings is shared and discussed with office and/or investigative staff to garner methods of improvement and to identify steps that will be taken to reduce or prevent discrepancies. Copies of these forms are maintained by the office administrator.

Unfinished case records are tracked using a variety of methods. The forensic pathologist assigned to each case is responsible for tracking unfinished autopsy reports and unsigned death certificates via case spreadsheets. The medical investigator assigned to each case is responsible for assuring all requested records are received, all documents are complete including

the final death certificate, and finalizing and "closing" the case within the electronic record system. Quality assurance reports including "Open Case Status" and "Pending Case Log" are run on a quarterly basis and all open or pending cases are reviewed and where possible, deficiencies or pending issues corrected. Reports run on a monthly basis include "Pending Death Certificate Signature" and "Pending Toxicology Cases" to monitor cases over six weeks old needing follow up to facilitate death certificate or toxicology completion.

The Annual Report serves as a major mechanism for yearly quality assurance for the medical investigators. During preparation of the Annual Report, missing, incomplete or erroneous data is highlighted for individual cases, and the medical investigator of record is responsible for entering or fixing the necessary case information.

Additional quality review includes tracking of scene response time for each medical investigator as well as response time for body transport services. If written complaints or commendations regarding [redacted] staff members are submitted by outside agencies or members of the public, these are retained within that staff member's personnel file after review. Job performance reviews are performed annually under the [redacted] Human Resource guidelines. Photographs taken by the medical investigators (scene photographs) and the autopsy assistants (examination photographs) are routinely reviewed by the pathologist assigned to the case and recurring deficiencies discussed with the individual; in addition, review of forensic photography practices is conducted at quarterly staff meetings.

Proficiency Testing Participation

The office will participate in external proficiency testing by means of the ASCP and/or CAP forensic pathology and autopsy pathology programs. Professional staff will meet as a team to discuss test materials. Any deviation from acceptable performance will be reviewed by all staff members. Forensic pathologists will maintain active board certification though the American Board of Pathology Continuing Certification program, as applicable.

Scheduled Activity

The staff pathologists, visiting residents and medical students as well as interns will meet regularly to discuss recent cases, particularly those of unusual nature. This conference will also be used for proficiency testing and quality review.

Quarterly Meetings

Quarterly mandatory staff meetings involving all personnel are held to discuss and refine procedures, answer questions, and implement suggestions for improving performance of our duties. They may occur more often should the necessity arise. Any deficiencies within the office pertaining to clerical, investigation, autopsy performance or death certification will be discussed and corrective action taken. A medical examiner quality assurance form is included in Appendix D.

Child and Maternal Deaths

In accordance with Colorado Law (Colorado Revised Statute 25-20.5 part 4), the office participates in a regularly scheduled Child Fatality Review Committee organized by the Colorado Department of Public Health and Environment (CDPHE). All coroner jurisdiction deaths in children ages 17 and under are reviewed on local and statewide levels. Likewise, the office has available representation on the CDPHE's Maternal Morbidity and Mortality Review Team and Domestic Violence Fatality Review Team, where all applicable deaths are reviewed on a statewide basis.

Histology

Quality assurance and proficiency testing for the histology lab are outlined in the corresponding Histology section of this Procedure manual.

Annual Review of Autopsy Performance

Following completion of the Annual Report, autopsy performance for the year is reviewed and compared to the previous years. Records related to ongoing autopsy reviews are assessed annually and evaluated for proper follow-up and improvement recommendations.

Policy/Procedure Violations

Violations of this policy are grounds for disciplinary action, up to and including termination.

Revised Effective: 10/18/2015
Revised Effective: 10/24/2017
Revised Effective: 09/28/2019
Revised Effective: 10/13/2021
Revised Effective: 11/01/2023

Approved by: [redacted]