HANDLE WITH CARE

Volume 6, Issue 2 **Fall/Winter 2009**

A Risk Management Newsletter for the Health Care Protection Program's Members

In this Issue:

Please feel free to copy and distribute as necessary.

If you would like to receive an electronic version of this publication just drop us a line at HCPP@gov.bc.ca and we will add you to our distribution list.

Health Team Leader's Message

As the lower mainland of BC prepares to welcome the world for the upcoming Olympic Games, some interesting risk issues are emerging. At the same time as thousands of visitors from virtually every country in the world are expected to enter our Province, understanding of the H1N1 influenza pandemic and its risks continues to evolve. The Risk Management Branch has been working to identify and manage its most critical risks related to both the Olympics and pandemic through the creation and roll-up of provincial risk registers. Informed by all affected agencies, the process has been valuable in revealing interdependencies and cumulative risk that might not otherwise have been identified.

In addition to assisting the health authorities to meet reporting requirements related to these provincial risk registers, business as usual continues at HCPP. In this issue of Handle with Care, we include an article regarding the essential elements of ***Informed Consent.*** The presence and degree of informed consent is frequently at issue in litigation. For those of our clients who manage risks in contracts, we delve more deeply into understanding indemnities in our article ***Indemnities in Disguise***. Following the decision in a recent case that was featured in the media, our ***Claims Abstract*** for this issue draws your attention to the importance of timely communication between medical imaging departments, patients and their physicians.

Capital asset and facilities management clients will want to take note of our ***Risk Wise Answers.*** In this issue we endeavour to help you understand what constitutes a "high hazard" or "unusual exposure" in the world of construction insurance. Finally, in our ***Hospital Corners*** segment we share some important risk management advice related to the use of ***Acronyms and Abbreviations.***

As always, we welcome any suggestions for future articles, risk tips you would like to share or initiatives you may like to showcase. Please do not hesitate to send your comments/suggestions to us at HCPP@gov.bc.ca

Linda Irvine, Director
Health Care Protection Program

Links of Interest

Risk at Home: Privacy & Security Risks in Telecommuting http://www.cdt.org/privacy/20080729_riskathome.pdf

Canadian Risk Management (CRM) Program — The three CRM courses offered by Simon Fraser University start again in January with CRM 205: Risk Assessment. Evening courses are scheduled at the downtown Vancouver campus, and in Victoria at Risk Management Branch. For more info: http://www.sfu.ca/cstudies/pd/rf.html or Email: mpp-info@sfu.ca

Informed Consent

Informed Consent refers to the legal duty on medical practitioners to appropriately advise patients about the nature and risks inherent in a proposed medical procedure or course of treatment and obtain their consent to proceed with the treatment. In the context of the Health Authorities, it is a process to ensure the patient's informed consent has been obtained as required by this duty.

In Canada, individuals have autonomy over their bodies. This includes the right to accept or refuse medical treatment. Patients generally have the right to refuse medical treatment, even when the potential benefit of the treatment outweighs the risks. The exceptions to this general principle are, one, in an emergency where the patient cannot give consent and medical treatment must be administered immediately, and two, where the patient does not have legal capacity to give consent. In the latter case, the substitute decision maker is empowered, often by statute, to make decisions regarding the provision of medical care to the patient. Where the patient lacks the legal capacity to make a decision regarding their own medical care, informed consent must be obtained by the substitute decision maker. Where there is a substitute decision maker, that person is required to adhere to the wishes of the incapacitated adult, so far as they can be known, and to make decisions that are reasonable and in the best interests of the incapacitated adult.

In order for a patient to decide whether or not to undergo medical treatment, the patient needs to be aware of the risks and benefits of the procedure in question. Medical practitioners have a duty to inform patients even if the patient does not ask questions or has otherwise not shown an interest in obtaining the information. Without proper disclosure given to the patient, or the patient's substituted decision maker, the patient's consent is vitiated; in other words, consent has not been given. Without the patient's consent, the medical practitioner who provides treatment to the patient commits the tort of battery and may be found liable in negligence.

When deciding what information to provide to a patient about a particular procedure or course of treatment, the medical practitioner must conduct a mini risk assessment. All known material risks must be disclosed to the patient. What is material depends on the likelihood of the complication occurring and the seriousness of the complication.

For example, if a possible outcome of a particular treatment is the patient's demise, the risk is serious enough that the patient must be informed of the risk even if the chance of its occurrence is remote. If the risk of a complication occurring is high, the patient should be informed of the complication even if it is not serious. If the risk of the complication occurring is remote and not serious, it is arguably not a material risk that needs to be disclosed to the patient. Whether a risk is serious will also depend to an extent on the individual circumstances of the patient.

Discuss risks and benefits associated with medical treatment.

This principle was recently stated by the courts as follows: a medical person must disclose those risks to which a reasonable patient would be likely to attach significance in deciding whether or not to undergo the proposed treatment. In making this determination, the degree of probability of the risk and its seriousness are relevant factors.

Of course, not only does a patient need to know the material risks inherent in the procedure, but also the expected outcome of not undergoing the treatment. Even if there is a good possibility of a serious complication arising from the medical treatment, the expected outcome of not having the procedure may be worse. Medical practitioners therefore must inform the patient of the risks involved in not taking the treatment. If the patient consents to the treatment, the medical practitioner must educate the patient on the clinical presentation of complications that may develop and what the patient should do about them.

Medical practitioners should take appropriate, reasonable steps to ensure the patient understands the information being provided. Being aware that the patient may be under a lot of stress and not be hearing or comprehending as they normally would is

(continued on page 3)

Informed Consent

(continued from page 2)

important. One must also be aware of any obvious barriers to communication and a proper understanding of information being provided. For example, English may not be the patient's first language and some patients may not have the literacy skills to understand the written word.

Most often the topic of informed consent is discussed in relation to treatment provided by physicians, given that physicians are the practitioners who are responsible for patients' overall care. It is the treating physician's responsibility to ensure that informed consent is obtained. This duty may be delegated to another physician. However, if the treating physician assumes informed consent has been obtained and it in fact was not obtained, the treating physician will be responsible for the lack of consent. Where a nurse administers treatment without a physician overseeing the treatment, such as in a public health clinic setting, the principles of informed consent will apply to the nurse.

Medical practitioners should develop standard procedures when it comes to informing patients of the risks and benefits associated with medical treatment. This assists in ensuring that the informed consent process has been completed. It also will assist should an issue arise regarding whether or not informed consent was obtained. Often such a problem is not identified until well after the fact, when memories have become unreliable or faded altogether. Examples of steps that can be taken include accurate and timely documentation of the process, including comments and reactions of the patients, which helps in establishing that informed consent was obtained. It is also useful to have the patient sign a consent form which outlines the basic material risks and benefits associated with the procedure. When using a standard form, however, practitioners should understand that merely having the patient sign a form is not enough to ensure informed consent has been obtained.➤

Hospital Corners— Quick Risk Tip

The use of acronyms and abbreviations

Acronyms and abbreviations can be helpful in saving time and in speeding communications. After all, when we talk about a CT scan we really don't need to say Computed Tomography for there to be near universal recognition. (Unless of course you are just getting back into fitness, in which case you may only be obsessing about that Certified Trainer about to give you the "look over").

Seriously though, acronyms and abbreviations can lead to confusion and error if they are not consistently understood. Take HTN for example. Understood as hypertension or high blood pressure no problem, but HTN is also "listed" and frequently used to indicate hypotension...which is, needless to say, the opposite condition...in addition to denoting histotechnology, healthy teen network, help the needy, home theatre network, harvest the net and hierarchichal task network....does it really matter you may ask?

If you can consistently figure it out from the context, maybe not. Take TPN, commonly understood as Total Parenteral Nutrition, it can also be Triphosphopyridine Nucleotide...so what was that doctor ordering again?

Ideally patient information is always clear and unambiguous. Acronyms and abbreviations such as HTN, that can and do lead to opposite interpretation, have no place in patient documentation.

And while we are talking about things that mislead or get misread, The Institute for Safe Medication Practices Canada has a list of abbreviations that they do not endorse – ones that have been around forever but are easily misread. The list has been adapted in the article "Dangerous abbreviations: U can make a difference!" http://www.ismp-canada.org/download/caccn/CACCN-Fall05.pdf. It bears looking at now and again.➤

Indemnities in Disguise

An indemnity is a promise to make whole, or take financial responsibility, for losses incurred by another party. An indemnity might be worded so that the indemnity is limited to certain types of losses or causes of loss or a maximum amount. You can't use an indemnity to transfer legal liability (as determined by courts), but you can agree that another party will be responsible to pay losses caused by your legal liability.

Indemnities must be reasonable; that is, they usually include things that would be covered by common law, fortuitous events that haven't happened yet, and things that are within the control of the entity granting them.

A Health Care Agency (HCA) indemnity must first be approved in accordance with the *Financial Administration Act,* (by either the Minister of Finance, or the Executive Director of Risk Management Branch). Failure to have an indemnity approved doesn't void HCPP coverage, however, some losses fall outside the scope of coverage. In these cases, failure to have indemnity approved may limit the HCA's ability to access other funding sources. Identifying all indemnities and putting them forward for approval is prudent risk management.

Many indemnities use typical language and phrases such as "indemnify and hold harmless" which make them easy to recognize. A sample indemnity clause might look like this:

> The HCA will indemnify and save harmless the Contractor from any losses, claims, damages, actions, causes of action, costs and expenses that the Contractor may sustain, incur, suffer or be put to at any time, either before or after this Agreement ends, where the same or any of them are based upon, arise out of or occur by reason of any claim of infringement of third-party intellectual property rights related to any Materials provided to the Contractor by the HCA in connection with this Agreement .

However, sometimes the language is not so obvious, making the existence of an indemnity harder to identify. An indemnity need not explicitly include the words "indemnify and hold harmless" to be an indemnity obligation. Some agreements do not consolidate all indemnity obligations in one or two paragraphs. For these reasons (among others!) it's important to read an entire contract very carefully.

An indemnity obligation may be present if the language appears to indicate the HCA may have to pay to make an entity whole after loss or damage has occurred. Indemnities may be masquerading in wording such as:

- accept responsibility for costs
- reimburse
- defend and pay
- obligation to repair or repay for repairs
- pay for damage
- pay all financial obligations, loss or claims
- assume liability
- compensate for losses or damages

A disguised indemnity might look something like this:

> The HCA agrees to *reimburse* "X" for the replacement cost for the items borrowed and damaged. The HCA further agrees that if it breaches any guidelines or rules and this should result either directly or indirectly in any costs and/or liabilities for "X", that the HCA shall be *liable for such costs.*

If you're not sure, submit the entire agreement to HCPP for review.➤

We welcome Submissions for our Newsletter!

Did you know we would gladly take submissions for articles for Handle with Care?

All articles received will be reviewed for acceptance before publishing. Please note that we cannot guarantee that we will use your article in the Newsletter.

Please submit your article to HCPP@gov.bc.ca … we look forward to hearing from you!➤

Claims Abstract-Delayed Imaging Reporting Causes Significant Injury

Background: Ensuring there are systems in place to detect human error is a significant aspect of risk management. Due to the volume of cases going through any Medical Imaging Department ensuring timely communication between Medical Imaging Departments, patients and their physicians can be a very challenging issue. This claim which went to trial with judgement July 7, 2009 exemplifies why such systems are so crucial for patient safety.

Mr. K. suffered from back pain. He attended his family physician who referred him to a sports medicine specialist, who, in turn referred him for a CT scan of his lumbar spine. The CT scan was conducted and the radiologist had some concerns and wanted a contrast CT scan conducted to determine the differential diagnoses. The concerns were that the scan indicated there may be a tumour or an infection in Mr. K's spine. Although requested to return for a contrast CT scan, Mr, K did not return. The CT scan films were misfiled, therefore not brought forward for review, and were not reported on until over a year later, when the patient again returned to the authority for care.

One year later Mr. K. was diagnosed with spinal TB meningitis. If the films had been reported on at the time of the CT scan or within a few months Mr. K. would almost certainly have recovered with no consequence. However the diagnosis was delayed, there were complications and Mr. K. is now completely incapacitated and requires constant care.

The evidence was the hospital had 3 different filing systems for medical imaging films. The main filing system contained films with completed reports. The films that had been recently completed and dictated were placed into slots designated as an area for "hot files". Films were kept in the hot file area for two weeks so the report and the films could be easily accessed for review by referring physicians and radiologists. Then the films were filed in the main filing area. A visual check was supposed to be made by the clerical person to ensure the report was in the bag containing the film before it was filed in the main filing area.

In cases where a report was not dictated because the radiologist wanted to review outside films or requested the patient to return for additional images, the films were placed in the temporary holding area in the film library specifically set aside for this purpose. The film and the requisition would be placed in a clear plastic bag so the requisition could be seen. These were kept separate and apart from the other films in the film library. When the patient returned for the additional studies, the clerk in the film library would take the original film bag into the CT room for the technician.

The films which were separate and awaiting further studies would be checked at least once a month by a clerk in the film library. If it was apparent the patient was not going to return, or there was an indication the patient was not going to return, the clerk was supposed to inform the radiologist and request the radiologist dictate a report.

The Meditech System in place for generating reports so payment for the Hospital services could be received from the Medical Services Plan had the ability to check reports that were being generated for each film that was done. Unfortunately, at the time of this occurrence that capability was not being used by the hospital staff.

There was no evidence presented by the Health Authority that Mr. K. was called regarding his contrast CT scan appointment, but the family physician's notes indicated that Mr. K. had told him (approximately 8 months later) he did not want to have dye injected into him. So it was presumed that Mr. K. at some point was contacted by the hospital about another CT scan. (The family physician had died prior to trial and Mr. K. was too disabled to testify at trial or on discoveries). Mr. K. was not told on the day of his original CT scan he had to return as he had left by the time the radiologist reviewed his film (4:30 pm on a Friday). Mr. K. never returned for his contrast CT scan even though his back pain continued. In addition, he did not return to his Sports Medicine Specialist to schedule another appointment to discuss the CT scan results as he had been requested.

Although it was uncertain exactly what happened to Mr. K'.s CT scan film it is accepted by the court the films were misfiled in the main holding area and never returned to the radiologist to dictate a report. More than a year later, the film was located and a report dictated by a radiologist. In addition, there was evidence from the representative for the hospital that films had previously been located in the main films library with no reports when they ought to have been in the temporary holding area. Further, there was no system in place in the department for tracking outstanding requests for further medical imaging testing.

(*Continued on page 6)*

Claims Abstract *(continued from page5)*

The hospital did not admit liability but that issue was not seriously disputed. The hospital argued that Mr. K., the family physician, the radiologist and the Sports Medicine physician were also contributorily negligent. Mr. K. also alleged wrongdoing on the part of the hospital, family physician, the radiologist and the Sports Medicine physician.

The Allegations: The hospital (legally the Health Authority) is alleged to be directly liable for having an inadequate tracking or monitoring system to ensure films are reported. The hospital is alleged to be vicariously liable for its employee misfiling Mr. K.'s CT scan without it being reported on.

The Outcome: The Court found the hospital's "established protocol was not followed in at least two respects: (1) department employees failed to advise [Dr. X.] or any other radiologist that arrangements had not been made to have Mr. K. return for a contrast enhanced CT scan; and (2) they failed to return Mr. K's CT Scan films to [Dr. X, the radiologist] or any other radiologist so they could be reported on, and instead, likely misfiled those films. The... hospital is vicariously liable for the negligence of its employees and the hospital was therefore found liable."

Additionally, the hospital was found "liable for its failure to have in place a system to monitor whether reports had been generated for all the films that were taken." It was agreed by all parties the hospital "had undertaken the task of having a system set up to ensure the accurate and timely reporting of films, that the failure to provide accurate and timely reports might result in a delayed diagnosis that could potentially have disastrous consequences for the patient, and that patients and physicians relied on the system to ensure that reports were done in a timely way."

The court also stated the following:

> "Any system that relies on human beings is naturally susceptible to human error. The fallibility of the hospital's protocol is reflected in the fact multiple employees were negligent in the discharge of their duties in this case; with the consequence Mr. K's CT scan went unreported for over a year**.** Nevertheless, it is in the failure of the hospital to take into account the foreseeability of such employee error by having in place a back-up system that I find it also departed significantly from the standard of care. The hospital recognized the extent to which physicians and patients relied on its system, as well as the potentially disastrous consequences that could befall a patient in the event of a breakdown in that system. It should have been apparent to the hospital that whatever system it instituted to provide radiology services had to include a mechanism to monitor the timely reporting of films. Indeed, the Meditech system the department used for billing purposes had that very capability, but it went unused by hospital staff. Given the magnitude of this systemic deficiency, coupled with the negligence of the hospital employees in the handling of Mr. K's CT scans, a high degree of fault must be attributed to the hospital."

The hospital was found to be 70% liable.

Mr. K. was found to be 30% contributorily negligent in "not taking reasonable care for his own health when he failed to return for the contrast CT scan after being requested to do so and when he failed to return to see [the Sports Medicine Specialist] to discuss the results of his CT scan."

Damages Awarded: $4.9 million

Lessons Learned: Hospitals (and therefore Health Authorities) are directly responsible for ensuring there is a system in place which tracks and monitors all patients to ensure the appropriate reports are written and delivered to the necessary treating physicians in a timely manner. It is not appropriate to rely upon a system which relies exclusively on staff. Technology is available to ensure the appropriate tracking and monitoring of all medical imaging testing occurs. It is very important to remember serious, long–term and catastrophic consequences can result from a system failure.

Every year HCPP receives many claims relating to the late delivery of a variety of tests, some of which contain critical information which requires timely treatment. Sometimes the patient is still in the emergency room or is not kept in the emergency department pending the results of testing. Sometimes the treating physician never receives the test and fails to follow up on the results. This is what occurred in this situation. The courts did not find the physicians liable for failing to follow up to obtain the CT scan results, despite two separate CMPA warnings regarding the same. As such, it is absolutely critical all imaging departments have a system that not only determines whether a report has been dictated but also whether a report has been sent to the treating physician(s).

The citation for this case is *Kahlon v. Vancouver Coastal Health Authority et. al.* 2009 BCSC 922. We would be happy to provide this case to anyone if unable to locate it.

Risk Buzz

HCPP regularly produces written risk management advice in the form of **Risk Notes**.

In addition to our data base of existing **Risk Notes,** HCPP is continually updating and producing new **Risk Notes**, whether in response to a specific request from one of our member entities or to address risk management concerns as we become aware of them during the process of investigating and settling claims.

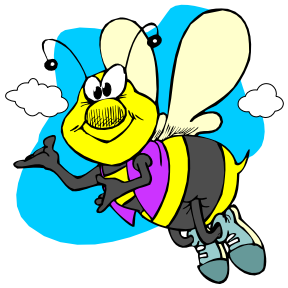
To date in 2009, HCPP has released six new/updated **Risk Notes**:

- Issues Relating to Death & Estate Administration
- Patient Property
- Capturing Images of Patients
- Health Care Providers Retained by the Family
- Risk Management in Contracts
- Records Retention

Coming soon in 2009:

- Confidentiality and Contracted Data Services
- The Risk Management Process

These can be found on the HCPP website or by contacting your organization's Risk Manager or Chief Risk Officer for a copy.➤



Risk Wise Answers

What is a "high hazard" or "unusual exposure" in a construction project?

The recently revised HCPP Construction Program Bulletin was released to all the Health Care Agencies (HCAs) in May 2009 prompting questions about the meaning of "high hazards" or "unusual exposures" noted in the bulletin. The revised HCPP Construction Program Bulletin can be found at: http://www.hcpp.org/content/pdfstorage/8902165346420098584 1AM66173.pdf or contact HCPP.

In short, "high hazards" or "unusual exposures" are terms that cannot be easily defined. For this reason, we ask HCAs to contact us when a project seems to pose higher than normal levels of risk. HCPP can assist in reviewing the risks and explore treatment options, including the need for additional insurance.

It is important to understand that just because a project is smaller (those under $1,000,000) it does not necessarily mean the associated risks are low. Potential high hazards or unusual exposures (level of HCA risk) may become apparent when considering potential injury to HCA staff, patients, visitors or damage to the HCA facility or surrounding third party property.

Here are but a few questions to assist project managers in determining if hazards or exposures raise the HCA's level of risk:

1. Are there any dangerous operations that increase the certainty of loss (e.g. hot roof applications, blasting, underpinning, tunnelling, demolition or crane operations)?
2. Is there a higher than normal exposure to a known hazard (e.g. building on a floodplain)?
3. Would the impact be more severe should an accident occur (e.g. close proximity to existing structures, on culturally significant properties or near a sensitive/ protected ecological site)?
4. Is the value of third party property surrounding the project high?
5. Would a loss affect a large population base (e.g. pollution)?
6. Is the project in a dense urban or commercial area (e.g. near high vehicle or pedestrian traffic)?

HCA project managers are the experts and the ones best able to identify any high hazards or unusual exposures in any construction projects. Where these exist, we recommend you contact HCPP (earlier better than later) so we can assist you with insurance, indemnity or risk management concerns.➤

About Our Organization...

We are the Client Services Team for the Health Care Protection Program (HCPP). HCPP is a self-insurance program which is funded by the Health Authorities of BC. The program is housed within the offices of the Risk Management Branch of the Ministry of Finance which also has responsibility for similar programs such as the Schools Protection Program, and the University, College & Institute Protection Program. As part of the services of our program, we provide risk management services including risk mitigation, risk financing and claims and litigation management to HCPP member entities including all the Health Authorities and various other stand-alone health care agencies in the Province of BC.

Our Team of Professionals

Linda Irvine – Director, Health Care Protection Program (250) 952-0849 Linda.Irvine@gov.bc.ca

Suzanne Armour—A/Risk Management Consultant (250) 952-0852 Suzanne.Armour@gov.bc.ca

Megan Arsenault—Risk Management Consultant (250) 356-6815 Megan.Arsenault@gov.bc.ca

Susan Beach—Senior Claims Examiner/Legal Counsel (250) 952-0839 Susan.Beach@gov.bc.ca

Dave Foxall – Risk Mitigation Consultant (250) 356-8718 Dave.Foxall@gov.bc.ca

Kevin Kitson – Senior Claims Examiner/Legal Counsel (250) 952-0840 Kevin.Kitson@gov.bc.ca

Blair Loveday – Senior Claims Examiner (250) 952-0841 Blair.Loveday@gov.bc.ca

Jeff Milne – Risk Management Consultant (250) 952-0784 Jeffrey.Milne@gov.bc.ca

Kim Oldham – Director, Claims and Litigation Management (250) 952-0837 Kim.Oldham@gov.bc.ca

Dragana Petzing – Risk Management Consultant (250) 356-6814 Dragana.Petzing@gov.bc.ca

Kathie Thompson – Senior Risk Management Consultant (250) 952-0848 Kathie.Thompson@gov.bc.ca

Grant Warrington – Senior Claims Examiner/Legal Counsel (250) 952-0849 Grant.Warrington@gov.bc.ca

Lori Watson – Risk Management Consultant (250) 952-0852 Lori.Watson@gov.bc.ca

Kathleen Werstiuk, Senior Claims Examiner (250) 952-0843 Kathleen.Werstiuk@gov.bc.ca

Sharon White – Senior Risk Management Consultant (250) 952-0850 Sharon.P.White@gov.bc.ca

We Need Your Feedback!

What do you think about "Handle With Care"? We always love to hear your comments. Please send us your feedback!

Are there any topics you would like us to cover? Email us at HCPP@gov.bc.ca

Handle With Care is published twice a year by the Health Care Protection Program

CONTACT INFORMATION

MAILING ADDRESS:
PO Box 3586
Victoria BC V8W 9V1

PHONE:
(250) 356-1794

FAX:
(250) 953-3050

CLAIMS FAX:
(250) 356-0661

E-MAIL:
HCPP@gov.bc.ca

We're on the Web!
See us at:
www.hcpp.org