HANDLE WITH CARE

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

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Health Team Leader's Message

Like all organizations within the public service, HCPP is challenged by the requirement to do more with less. In the same way our clients look for new and innovative ways to deliver services, so too do our consultants and claims staff seek out these types of efficiencies. Having a structure conducive to the elimination of duplication and supportive of improved communication is one way efficiencies can be achieved.

I am therefore very pleased to announce the release of our first Narrated Power Point publication – HCPP 101. Narrated Power Points are a means to deliver foundational knowledge about the HCPP program and its services. In recognition of the varied audiences who may have an interest in this information, we have endeavoured to make the presentation as broad as possible. We hope its content will be useful in answering that ongoing question – just who is HCPP? And why should I need to know?

In this issue of Handle with Care you will find an article on ***Effective Communication Between Registered Nurses and Midwives***. This topic has been identified by HCPP as one deserving of attention and having the potential to not only reduce loss, but possibly save lives. We hope you will read with interest the advice provided by Grant Warrington, who is able to speak from the position of witnessing the unfortunate consequences of failed communication.

There is also much to be gleaned from our Claims Abstract. Learn from the ***Forde Case***, the importance of having systems that are reliable and demonstrably in keeping with industry standards. The key to systems, of course, is that having them is not enough. Staff must be kept informed and regular review and monitoring is essential to ensure awareness and compliance.

On the insurance front, we include another reminder of the importance of placing construction insurance under the Provincial Construction Insurance Program. Check out ***Risk Wise Answers*** for more detail on this highly valuable risk advice. Failure to heed it has the potential to cost your organization thousands of dollars.

Those who make use of the ***Master Insurance Program*** will want to know about changes to the enrolment process, to a web-based format. These should come as no surprise to anyone who is up to speed with technological advances but you will want to ensure understanding of how the changes specifically impact your organization. Read about it on Page 8 of the newsletter.

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

A New Publication from HCPP—Narrated Power Points

We've created a new publication—Narrated Power Points, which will share some of our most popular education sessions via our website.

You can now listen to our presentations online without ever having to leave the comfort of your own work place.

Our first Narrated Power Point, HCPP 101, is available at HCPP@gov.bc.ca or by contacting your organization's Risk Manager or Chief Risk Officer. ➤

Effective Communication Between Registered Nurses and Midwives

Effective communication is a constant challenge for all of us. What I have learned from our experience with cases reported to both the Health Care Protection Program and the Midwives Protection Program is that certain communication patterns or problems seem to repeat themselves in obstetrical settings.

In this article I will try to set out a few of those examples to illustrate how effective communication and preparation can assist both Registered Nurses and Registered Midwives. Of course the same principles and considerations will apply to relations with other health care providers but the focus of this article is on the dynamics between nurses and midwives in a hospital setting.

One of my frequent observations is that for nurses and midwives who have practiced in other jurisdictions, or for midwives who have recently acquired privileges in a new hospital, it is imperative that the nurse or midwife familiarize him/herself with the procedures and guidelines of the new setting(s). It is unsafe to assume policies and procedures are the same between one country or province and another and in many respects the same consideration must apply as between hospitals, particularly between health authorities but also for different hospitals within the same health authority. For example, where a midwife has privileges at more than one hospital there may well be different expectations for history taking and completion of discharge summaries. There may be different staffing ratios and the ability of RNs to assist in a particular delivery may differ from hospital to hospital due to experience or staffing levels or local policy considerations.

Both nurses and midwives frequently acknowledge in investigations that they have not taken the time or effort to familiarize themselves with a new work environment. In some instances nursing orientations have been lacking. In other instances policies and procedures that differ as between health authorities, or are inconsistent or unevenly applied in different hospitals within the same health authority, have made the health care providers' lives more difficult than need be.

Both midwives and nurses need to be aware that College of Midwives directives may require a different standard e.g. when to consult with an obstetrician, than other staff, including medical staff, might follow. In general if there is a difference between a College directive or guideline and a hospital policy the more rigorous or exacting requirements should be followed. If a midwife makes it clear to nursing staff questioning a decision that her College requires a different approach this may enhance a greater understanding of their respective roles.

It is not always clear to midwives or nurses what they can do if they do not agree with another health care provider's decision. Does the midwife or nurse understand the chains of command and how disputes should be resolved? Too frequently differences of opinion arise in the midst of providing urgent care. These can include differences of opinion that repeat themselves and yet have not been properly anticipated with steps taken to resolve the issues ahead of time.

Midwives must pay particular attention when they are serving clients who may end up in an unfamiliar hospital due to lack of choice, urgency or timing. Clearly not all planned homebirths will remain at home and once they move to hospital, often at short notice, there is little time to learn the environment, meet staff or read critical policy or procedure. Prepare for these contingencies ahead of time, where reasonably possible, and give nursing staff sufficient information to assist you so that they too can provide the best care possible. Best practice will be for a midwife to visit the hospital where she has privileges ahead of time and to introduce herself to staff. When attending for the delivery the midwife and RN in charge should discuss relevant matters such as staffing levels, patient loads, which obstetrician and paediatrician is on call, levels of experience and familiarity with working with midwives, and expectations for charting.

An essential part of the midwife's client preparation and birth plan is to ensure that the

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client's transfer and transition to hospital care is as seamless as possible. This includes knowing the culture of the facility and being as familiar as possible with the expectations, the guidelines and local policies and procedures: some of which may differ from practice in other facilities.

Conflict or misunderstanding over local policies can lead to significant problems for all care givers and leave clients and families wondering if they are in safe hands: especially so where tension or dispute arises in their midst.

Knowing local procedures and, where possible, the expertise, expectations and limitations of nursing and other health care providers ahead of time can make a sudden change in condition or transfer of an at-home client to hospital less stressful for all concerned. For the registered midwife this may mean taking the time to visit the facility ahead of time and introducing yourself to the staff. For the registered nurse on duty when a midwife is providing care this may mean stepping forward and stating your level of experience and/or ability to provide care given other patient demands and/or staffing levels.

It is important to try to know and understand each others' skills and limitations. Equally, if not more, important is to know your own skills and limitations and to be able to state those clearly. This is especially important as between the primary care giver and the second attendant, be that second another midwife or a nurse. Nursing staff do not always fully understand the midwife's role or agree with a particular assessment. Conversely the midwife may have a different expectation of the nursing staff or second attendant's role(s) in a particular delivery or a different assessment of the urgency or condition of a client or infant. Effective and timely communication, and clarification where necessary, with all staff will help ensure best outcomes.

Where the midwife's arrangements are with a second attendant at another practice at some distance from the client consider whether that distance or the means of transport will, given changing weather conditions, ferry or other delays, be appropriate for the client's changing needs should a hospital birth become necessary. Consider ahead of time whether the hospital nurses will be ready to assist. Giving a heads up helps everyone concerned. Obviously not all nurses and not all midwives working in an obstetrical setting will have the same level of experience, confidence, expertise or specialized training. Uncertainty about who can, or who is willing and/or able to do what has led or contributed to some unfortunate outcomes or close calls for clients and their families and for the nurses and midwives providing care. By knowing strengths AND your own limitations, which can change from one birth to another or even during the course of a difficult labour and delivery, you are better serving your client, your profession and your relationship with other health care providers.

Not all Midwives and not all RNs have the same qualifications or skill sets and any advanced competencies or qualifications (or lack of same) should be clearly communicated rather than assumed.

There should be no shame for a midwife in asking an available obstetrician to take over suturing a client if the midwife is too tired or if the tear is of questionable severity and repair more complex. A registered nurse should not hesitate to ask: "Do you need any help?" or "Do you need me to call the obstetrician or paediatrician or other back up?" Proactive and assertive communications lead to better outcomes in these situations.

There should also be no hesitation in the midwife asking a nurse or her supervisor to ensure the midwife is given the same level of assistance and cooperation that a doctor delivering the infant would be able to count on. Registered nurses for their part need to understand what a midwife's expectations are and not, as has happened in some unfortunate cases, leave the midwife without the level of support or cooperation a doctor would receive.

Communication is not only the direct discussion, orders or casual banter that may occur during delivery; it includes how the record is recorded. It should be clear in any delivery who will be responsible for what observations or measures or actions are to be

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taken and by whom. Effective communication includes who charts what and where and when. Ideally all of this is clear to the relevant caregivers well ahead of time. If APGARS are going to be altered (not uncommon) or if there are differences in interpretation of foetal monitoring (a frequent challenge) or if there is disagreement in an assessment, it is imperative that there either be some effort at accommodation or a common understanding, or, at a minimum, an explanation for the differing interpretation must be given in the form of a timely addendum to the patient record.

Where a client's care has been transferred to an obstetrician the continuing role of the registered midwife as support-only, if that is the case, must be made clear to everyone concerned. If care has been transferred back to the midwife, nursing staff need to be aware of that transfer, as does the client and her family. Confusion about who is responsible for providing care have left families feeling abandoned or wondering who is responsible for what and when. It can also jeopardize safety.

In hospitals where midwives have privileges but do not have midwifery departments or divisions or a clearly defined review process there are some unique challenges for all staff. Quality reviews are an important part of improving overall care within the hospital and any efforts to promote the inclusion of midwives in obstetrical reviews can greatly benefit everyone. Get to know each other professionally and build trust before problems arise, where possible, as these measures can reduce surprise criticisms or negative discussion. A quality review of a hospital birth taking place in the absence of the midwife providing care is not acceptable: the midwife and her department head or representative should always be included for their input.

Communicating effectively includes thinking ahead, (sometimes outside the box), looking for opportunities, discussion, consultation, documenting and reviewing care to ensure the kinds of positive outcomes we all want to enjoy for our clients, patients, families and ourselves as caring human beings.➤

Grant Warrington RPN LLB MA CRM

Hospital Corners— Quick Risk Tip

The Master Insurance Program and changes to the enrolment process

Health Care Agencies frequently identify Service Providers who are eligible for Insurance through the Master Insurance Program (MIP). Specific insurance language is then included in the contract which will trigger the two million dollar Commercial General Liability coverage that MIP provides these Service Providers.

The second part of this process involves enrolling the Service Provider and the contract into MIP. Pertinent contract information such as the contract number, contract term & value, and Service Provider's name are reported through the Ministry of Health Services to the insurance broker.

Failure to complete the enrolment process negatively affects the Program itself and also has consequences for the Service Provider. Enrolment is relied upon to determine the distribution of premium payments among ministries. Enrolment of the contract also ensures that the Service Provider will receive documentation evidencing proof of their coverage. We recommend that all Health Care Agencies have a system in place to ensure the enrolment process has been completed for every contract that has provided the Service Provider with MIP coverage.

Last year alone the Health Care Agencies enrolled over two thousand of their contracts into MIP. Effective this fall, the enrolment process will undergo some slight changes. The enrolment will be completed through a different website and will prompt users for the Service Provider's email address. More information about these changes will be delivered to the Health Care Agency's Risk Manager or Chief Risk Officer in the coming weeks.➤

Risk Wise Answers

Why is it so important for a Health Care Agency to place construction insurance under the Provincial Construction Program?

In May 2009, HCPP provided all the Health Care Agencies (HCAs) with a copy of our Construction Program Bulletin notifying them to place all construction projects valued at $1,000,000 or over under the Provincial Construction Insurance Program. The Program follows Provincial government policy which HCA's are required to follow as government agencies. The supplementary construction insurance and indemnity language within the Program was developed by the Risk Management Branch representing the Province after extensive negotiations with the construction industry, owners and architects and can be found at: http://www.fin.gov.bc.ca/PT/rmb/ref/cp/Health%20-%20Owner%20Insured%20Projects.pdf.

This article outlines risks that we have identified should an HCA not place insurance under the Program:

1) HCPP does not cover construction risks undertaken by contractors so the HCA may not be protected if your contractor is uninsured or is under-insured.

2) The contractor's insurance policies may not appropriately cover the HCA's interests in the project or they may possibly limit your access to the insurer.

3) The contractor's (or their subcontractor's) insurance may be inadequate to cover some construction risks (e.g. narrowed coverage or exclusions for certain risks commonly covered under broader policies), possibly because of the high costs to maintain such coverage.

4) The contractor's insurance may be shared amongst others (i.e. one policy covering all their projects).

5) Should there be no insurance or if the limits are too low to cover a claim, the HCA may be faced with absorbing costs from within their own budget if the contractor is not financially strong enough to pay.

6) If the HCA's budget were affected and the project was audited, the HCA would not be in compliance with government policy and the HCA would also be open to public scrutiny.

7) After a claim and without the appropriate coverage in place (e.g. builders risks and wrap-up policies), the project may be delayed because of contractor disputes over who is at fault and which insurance policy (often there are many involved) will respond.

8) The HCA could be held in breach if the project contract does not properly aligned with the insurance placed.

9) The HCA is also very likely paying more than necessary because the contractor includes insurance within their fees (i.e. contractor's cost for insurance is subject to their 10 % to 35% mark-up).

The insurance negotiated by the Province under the Program reduces the HCA's construction risks because it is purchased directly by the HCA, provides broad coverage, is project specific, limits are appropriate for the average project risks or can also be adjusted for higher risks, protects the owner and all contractors in the projects, and removes the issues around subrogation amongst the parties to the contract.

Another valued source of information can be found at: http://www.hcpp.org/content/pdfstorage/19339478610192009347 21PM87097.pdf. HCPP consultants are insurance experts and we are available to answer the HCA's questions directly, or call (250) 952-0846 or email hcpp@gov.bc.ca.

Claims Abstract— Examination of Health Authority Systems Avoided due to Physician's Adherence to Standard of Care

Background: The Plaintiff sued the Health Authority and a number of her treating physicians, the main one being the neurologist Dr. F, for a delay in the diagnosis of a rare condition known as posterior fossa dural anteriovenous fistula (AV fistula, also known as arteriovenous malformation or AVM). In May, 2002, the Plaintiff experienced mild urinary incontinence, the first symptoms of AVM. Approximately 6 months later, when the diagnosis of AVM was made, the Plaintiff was largely dependent upon a wheelchair for mobility. Her argument against the Health Authority was that the Health Authority did not have the appropriate systems in place for the timely ordering and triaging of diagnostic tests.

From the late 1990's to the early 2000's, the Plaintiff experienced a number of neurological conditions, including carpal tunnel syndrome and, in early May, 2002, she was diagnosed with spondylolisthesis at L5/S1. Later that same month, at the age of 46, the Plaintiff began experiencing mild urinary incontinence. This was the first symptom of many she would develop indicating a spinal cord dysfunction. In May and June, 2002, her family doctor sent her to a number of neurologists for an assessment of her bladder and other symptoms. By mid June, 2002, the Plaintiff had begun seeing one neurologist, Dr. F, who decided that the Plaintiff should undergo testing to rule out the possibility of spinal cord compression. On June 20, 2002, Dr. F ordered a spinal myelogram.

The spinal myelogram was to be performed at the Hospital. The protocol then in place for requesting such tests at the Hospital was that they could only be ordered by physicians. Requesting tests using CT scans and MRIs could for the most part only be done by specialists. To order a test, the doctor completed a requisition form. The test ordered by Dr. F needed to be prioritized due to high demand. The form Dr. F used required him to fill out one of three boxes, depending on the level of urgency for the particular patient. These boxes were labelled Emergent, Urgent and Elective. The Emergent test would usually be completed in a day or two.

The waiting lists for MRIs and CT scans for the Elective category were between 7 and 12 months.

According to the protocol, once the ordering physician had prioritized the test based on these three categories, the form would be sent to the radiologists working out of the Hospital. It was then up to the radiologists in making a final determination on the priority given each requisition. The ordering physicians were not automatically advised when the test was scheduled, but they could phone the Hospital to obtain this information. They also had the opportunity to speak with the radiologists to make their case for why a patient should be given higher priority. The radiologists were not employees of the Health Authority.

Dr. F left it up to the radiologists to decide whether the spinal myelogram he ordered on June 20, 2002 should be done by X-ray or CT scan. The CT scan provides the more detailed assessment, but unlike the X-ray, had a wait list. The radiologist decided a CT scan should be done and booked the test for July 13, 2002. This test was later cancelled due to a staff shortage in the Hospital. In late July and August, 2002 the CT scanner was not available as it was being replaced with a newer model.

On July 22, 2002, the Plaintiff called Dr. F and requested the CT scan be expedited. The next day Dr. F forwarded a request to the Hospital asking that the CT scan be expedited. He described the request as Urgent. The CT scan was scheduled for August 21, 2002. However, on August 13, 2002, the Plaintiff in conjunction with Dr. B, one of the radiologists at the hospital, asked Dr. F to change his request from a CT scan to an MRI. The MRI test gives a more complete picture than a CT scan, but the wait list for the MRI is lengthy. On the same day, Dr. F agreed to the change and submitted a requisition for an MRI. He did not indicate whether the request was Emergent, Urgent or Elective. The CT scan was cancelled. On August 14, 2002, Dr. B sent a fax to Dr. F with the question of whether Dr. F was requesting an MRI of the whole spine or lower

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spine. Dr. F wrote "yes" on the fax beside Dr. B's question. Dr. F at that time also circled the Urgent category on the form.

On September 5, 2002, the Plaintiff saw her family physician and advised that her back pain was very bad, to the point where she was going to apply for handicap status. On September 10, 2002, Dr F was made aware of the Plaintiff's pain. He was asked whether any treatment could be explored while the Plaintiff waited for the MRI. As a result, Dr. F wrote to Dr. B on September 12, 2002 asking if the Plaintiff's MRI could be scheduled within 3 to 4 weeks. The Plaintiff had an MRI on October 8, 2002, but Dr. B had understood that the MRI was to be of the lower spine only.

Dr. F had asked the Plaintiff to advise him if she ever became frankly incontinent. On or about the middle of September, 2002, the Plaintiff did become frankly incontinent. However, Dr. F was not advised of this development until the Plaintiff saw Dr. F on October 22, 2002 to review the results of the MRI. After the October 22 meeting, Dr. F immediately requisitioned an MRI of the Plaintiff's whole spine. The MRI machine used by the hospital was mobile and the hospital did not have use of it during the week of October 22, 2002, so Dr. F advised Dr. B that the test should be done the following week. The second MRI was conducted on October 29, 2002. The test revealed an abnormal lesion in the upper cervical cord region. Dr. F considered a number of possible diagnoses and arranged for the Plaintiff to be admitted to hospital on October 31, 2002. On the day of her admission she was seen by Dr. O, a neurologist, and in the subsequent four days a number of tests were performed on the Plaintiff, including a CT angiogram of her head.

In his report of November 8, 2002, Dr. B indicated the result of the CT angiogram was that the Plaintiff had abnormal vascular structure in the posterior fossa likely representing an AVM. The Plaintiff was discharged from hospital on November 7, 2002.

Dr. F followed up on these results by requesting a catheter angiogram be done immediately. Dr. F indicated on the form that Dr. B recommended the test was Urgent and should be conducted within one week. Dr. F also indicated on the form that he was considering a possible diagnosis to be transverse myletitis and post cerebellum aneurysms. The CT angiogram was carried out on November 15, 2002. In his report of November 18, 2002, Dr. W indicated that the test revealed an AVM.

The court noted that, as of November 15, 2002, there were two possible diagnoses for the Plaintiff's symptoms: transverse myelitis or AVM. On November 26, 2002, Dr. F contacted a vascular surgeon in Vancouver requesting a consultation. The Plaintiff continued to see Dr. F and Dr. O. She had a further MRI in mid January, 2003. Dr. O held the opinion that the Plaintiff had transverse myelitis. The vascular surgeon, Dr. R, saw the Plaintiff on April 9, 2003 and concluded that she was most likely suffering from AVM. An operation to repair the AVM was performed on April 24, 2003.

Although the operation to repair the AVM was considered a success, the Plaintiff did not regain mobility and remained heavily dependent on a wheelchair. The Plaintiff did not follow her doctors' advice regarding rehabilitation. Her condition worsened. After further medical investigation, it was determined that the lack of recovery was most likely due to the Plaintiff's deconditioned state and consequent weight gain. Despite the court finding that the Plaintiff could have regained some of her mobility had she followed the doctors' plans for rehabilitation, the court also found that she suffered permanent damage as a result of the AVM.

Allegations: The first main issue in the litigation was whether or not Dr. F fell below the standard of care in the timely ordering of diagnostic tests and the following up with appropriate treatment for the Plaintiff's condition. The second was whether the Health Authority had in place the systems for the ordering and conduct of such tests that met the appropriate standard of care. All parties to the litigation agreed that, if the court found Dr. F had not fallen below the appropriate standard of care, then the Health Authority could not have fallen below the appropriate standard of care in devising systems and protocols to ensure that tests were performed in a timely manner.

The court also considered the issue of causation: that is, even if appropriate diagnostic tests had been completed much sooner, would

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the reparative surgery have been completed in time to prevent the injuries.

The Outcome: The court determined that Dr. F met the standard of care of the average neurologist in similar community circumstances. As such, he was not liable for injuries that may have been caused to the Plaintiff as a result of the delay between the onset of her symptoms and the surgery required to treat her condition. Since the Court found Dr. F not liable for the Plaintiff's injuries, it consequently found the Health Authority was not liable.

The court dealt briefly with the question of causation and determined that the evidence failed to show that a much earlier diagnosis of AVM would have prevented the Plaintiff's injuries.

Lessons Learned: From the perspective of the Health Care Protection Program and the Health Authorities, it is unfortunate from a purely legal perspective that the court did not assess in detail the evidence or legal questions surrounding the determination of a standard for Health Authorities "systems" and the administration of medical care in these circumstances. At trial, the Plaintiff presented expert evidence that the systems in place at the Hospital fell below the appropriate standard. The expert was an administrator within the medical system in California and in essence he compared the systems in place at the British Columbia Hospital with those in place in California. Regarding the Plaintiff's expert and the standard of care for the Health Authority, the court stated, at pg 35:

> As far as the Hospital is concerned, quite apart from the position of the parties that if [Dr. F] was not liable that the Hospital was not liable, the evidence did not prove that the Hospital had breached its duty of care in any event.
>
> Although [the Plaintiff] led evidence that in the United States there are testing systems that have clearer forms and more checks and balances than the testing system utilized at [the Hospital], the evidence fell short of proving that these differences constituted a breach in the standard of care and, in particular, that the Hospital's systems and protocols fell below the standard of care expected of a hospital in a similar locality under similar circumstances. Rather, this evidence went no further than to show that more complete systems exist elsewhere than the system used by the Hospital.

Often enough Health Authorities are confronted with allegations that their "systems" are deficient and this deficiency caused or significantly contributed to the Plaintiff's injury. These allegations are typically made in conjunction with allegations that the individual doctors, nurses and other medical staff did not perform up to the appropriate standard. These cases are virtually always resolved, either through the settlement process or at trial, on the question of the standard of care of the individual practitioners involved. In this case, the court decided, with the agreement of all the parties, that the need to consider the Health Authorities systems would only have been necessary if the doctor fell below the standard of care. Despite this decision, the court did make a few brief comments on the Health Authority's systems, as discussed above.

There are a number of difficulties plaintiffs encounter when asserting that a Health Authorities' systems are below an accepted standard. As is apparent from this case, the first would be that arguably in many types of medical malpractice cases, the Plaintiff may well have to first show that the treating physician fell below the appropriate standard before the question of the Health Authority's systems is addressed. Second, it may be difficult to separate a physician's negligence from the standard of a medical care system.

For example, in this case, had the court found Dr. F to have fallen below the standard of care, the Health Authority could argue that whether its systems were at the same level as some applicable standard, Dr. F was an experienced neurologist with years of experience using the system that was in place. Even if the system could be shown to be below some applicable

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standard, Dr. F arguably was aware of how to use the system in place to obtain the required results for his patients.

Thirdly, a Health Authority's "systems" are often driven, at least in part, by resource decisions within the purview of the government. In other words, the courts are not able to question resource allocations made by governments, but only whether the resources that have been allocated have been operationalized in an appropriate manner. If a Health Authority needs 10 MRI machines in order to ensure all who require an MRI receive the test quickly, but only has the resources to purchase one MRI, the Health Authority cannot be faulted by the courts for only having one MRI.

This case does assist the Health Authorities somewhat by suggesting that in order to show the Health Authorities systems have fallen below a standard of care, that standard and the evidence to support it will have to take into consideration unique attributes of the Health Authority in question in order to be of any value. In this case, Plaintiff's counsel relied on an expert from the United States, which, although not dealt with by the court, has a very different system of medical care in general from that of British Columbia.

But for the fact the physician(s) in this case were not found liable, the Health Authority "systems" would have been subject to more scrutiny, positive or negative. This is not an isolated incident and Health Authorities will continue to be challenged on their decisions regarding the implementation of resources. The costs to the Health Care Protection Program alone for defending this case exceeded $200,000.00. By recognizing that their "systems" are a target of litigation, the Health Authorities can strive to ensure that these systems are as effective and efficient as is reasonably possible given the resources they are allotted.

Kevin Kitson, BA, LLB

Risk Management Conferences

- RIMS 2011 Annual Conference —May 1-5, 2011 Vancouver, British Columbia
  http://www.rims.org/annualconference
- 2011 Rims Canada Conference September 18-21, 2011 Ottawa, Ontario
  http://conference.rimscanada.ca

Links of Interest

- Risk Management Magazine
  http://www.rmmagazine.com/
- Canadian Risk Management (CRM) Program
  Simon Fraser University offers evening courses toward CRM designation in downtown Vancouver and downtown Victoria. For more information call them at 778-872-5095, see http://www.sfu.ca/cstudies/mpprog/business/risk/ or send and email to mpp-infor@sfu.ca

  University of Northern British Columbia offers weekend courses toward the CRM designation in Prince George. For more information call them at 1-866-843-8061, see http://www.unbc.ca/continuingstudies/certificates/riskmanagement.html or send an email to cstudies@unbc.ca.

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.➤

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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

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