HANDLE WITH CARE

Volume 8, Issue 2 **Fall/Winter 2011**

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

In this Issue:

Did you know our website is currently under construction? Watch for a new look and feel in early 2012!

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Health Team Leader's Message

Facilities and property are an integral part of the health care system. While the clinical nature of health care presents risks that are often unique to those working in the profession, there are risks that are universal to the ownership and use, for example, of buildings and vehicles.

This edition of Handle with Care asks us to consider the effective use of automatic sprinklers and how to get the most from the protection systems we rely on. ***Automatic Sprinkler Systems*** provide life safety as well as property protection and the importance of maintenance cannot be overlooked.

In our ***Risk Wise Answers*** we respond to a number of insurance questions related to the fleet vehicle insurance program. There are advantages to being part of the fleet program, available to all public sector entities. We also explain how ICBC coverage dovetails with HCPP coverage.

We revisit the issue of ***Bed Bugs***, a topic that was first covered in our Summer 2008 issue. These pesky parasites continue to assert themselves and require our ongoing diligence in risk management.

We take you into the world of claims investigation and management in our article on ***What to do when faced with a Property Claim***. Understanding the immediate and subsequent steps in the process will ensure successful reporting, investigation and conclusion after an insured property loss.

Finally, our ***Claims Abstract*** draws your attention to the risks of releasing patients who may be under the effects of medication. The duty to provide a safe environment for patients and others extends beyond the doors of the health care facility.

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—Client Services
Health Care Protection Program

Dealing with Bed Bugs in a Health Care Facility

We first wrote about bedbugs in the "Don't Let the Bed Bugs Bite" article that was published in the Summer 2008 issue of Handle with Care. It's over three years later and bedbugs continue to be a problem in our health care facilities as well as other public spaces such as libraries, dorm rooms and movie theatres. In the United States there are press reports of lawsuits being brought against hotels with settlements being negotiated ahead of litigation and considerable damages awarded. In Canada most of the litigation is limited to claims by tenants against landlords due to infested rental units, but stories about bedbug discoveries and infestations in public spaces are making the news throughout the country including recent media speculation that bedbugs may be able to spread diseases to humans.

Naturally, Health Care Agencies (HCAs) want to protect their clients from any negative experience occurring in their facilities but the reality is bedbug encounters do occur, even in hospital settings. A hospital, however, is different from a hotel or a rental unit. The main reasons why hotels tend to negotiate and settle lawsuits regarding bed bugs are publicity reasons that may lead to loss of business. These

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concerns do not apply to hospitals. The high level of traffic in hospitals also justifies isolated bed bug incidents. Barring a major infestation that is not treated for a prolonged period of time, the possibility of a successful lawsuit is low. Nevertheless, the resilience of bed bugs and the possibility, however remote, that they may be able to transmit communicable diseases warrants preventive measures and a prompt response once detected.

The Health Care Protection Program, as the program of self-insurance for HCAs in BC, has seen an increase in the number of cases of bed bugs that have been reported. While eradication of bedbugs can be time consuming and expensive, these types of claims generally do not represent a compensable claim as there is often no bodily injury or property damage sustained in the incident. When faced with uninsurable risks, putting good risk management practices into place is even more important.

In comparison to many other organizations, HCAs can't regulate the comings and goings of their clientele which makes some prevention strategies less practical for implementation. It only takes one visitor to bring in bedbugs on their clothing or handbag to introduce a new potential for a bedbug infestation. Many preventive measures are in fact ways to simply reduce hiding spots for bedbugs enabling the HCA's to detect an incident earlier.

Prevention Measures:

- Minimize use of high risk fabrics on hospital furniture
- Repair or discard furniture that is in disrepair
- Utilize mattress encasings
- Remove all clutter
- Fill any cracks in walls
- Utilize Bed Bug Saunas

Early identification and diagnosis are key components of a prompt response that will assist in keeping a bedbug incident isolated. Inspect proactively, treat reactively should be the bedbug mantra.

Early detection and treatment:

- Assess patients with nocturnally acquired bites or rashes
- Take any accounts of sightings seriously
- Routinely look for evidence of small
- reddish brown stains or spots on sheets/ matresses
- Train staff on what to look for and how to treat bedbugs
- Involve a licensed pest control company when necessary
- Conduct DNA and/or canine testing

It is difficult, if not impossible, to prove where bed bugs in a HCA came from and that the infestation is due to negligence on the part of the HCA. Prevention and early detection should be the focus and every HCA should look at their processes for controlling an infestation. All HCAs need to have an appropriate standard for the prevention and early detection of bed bugs which becomes a reasonable expectation to meet.

While HCAs should be aware of new technologies this doesn't necessarily mean they have to implement them all in order not to be considered legally liable for a bedbug incident. The onus is on the HCA to create a safe environment but any assessment will be based on what is reasonable under the circumstances. When evaluating reasonableness, considerations will be made with respect to things like the type of organization, the financial resources available to the organization and the practices of similar organizations in BC. For instance, DNA and canine testing are both methods of early detection to see if bedbugs have been in a room but they can be costly and time consuming. Bedbug saunas are very effective in controlling bed bugs using heat. BC Housing developed guidelines for this treatment method and construction of these "heat treatment rooms", at a cost of approximately $16,000 each, is part of their Integrate Pest Management Program. These degrees of early detection and treatment may not be deemed reasonable and/or practical in a hospital setting that has a high volume of traffic and where health care dollars are limited and in such high demand.

Every HCA owes a duty of care to patients, visitors and employees to ensure that their facility is safe and free from harm. The HCAs should be aware of new technologies and assess them for implementation, take reasonable precautions to prevent bedbugs and, at minimum, HCAs should have a policy in place on how to treat them when they are detected. This policy should be communicated to all staff so they can act quickly in response to any incident and prevent further damage. Adoption of these practices not only ensures the HCA upholds its duty of care to all individuals on site, it is good risk management.

Risk Wise Answers—Fleet Insurance Q&A

Q—What is the "fleet" vehicle insurance program and what are the benefits to Health Care Agencies?

The "fleet" vehicle insurance program is a government program, in which government ministries, Health Care Agencies (HCAs) and Community Living BC (CLBC) participate, providing automobile liability insurance coverage for their owned or leased vehicles. The Insurance Corporation of British Columbia (ICBC) provides this coverage under a master policy issued to the Province. Instead of insuring each vehicle on an individual basis, being part of the fleet vehicle insurance program gives the benefit of reduced rates and ease of moving vehicles from one address to another in the Province. The savings in rate reduction are between 40-60%.

Q—Who manages the fleet insurance program? Who deals with ICBC? What do HCAs have to do for reporting vehicles to the fleet?

The Risk Management Branch established the fleet insurance program and continues to manage it today. The program is delivered by the Purchasing Services Branch at the Ministry of Labour, Citizens' Services and Open Government (LCS). LCS gets a monthly report from ICBC on all the vehicles registered under the fleet program. LCS pays the premiums on behalf of the ministries, HCAs and CLBC and in turn recovers these costs from each entity. Each HCA has a fleet coordinator who reports the number of vehicles directly to ICBC.

Q—How is the premium established for the fleet insurance program?

The premium charged is based on the experience of the entire fleet versus just one vehicle. This gives a substantial discount because risk is spread over many vehicles - the more vehicles that are part of the fleet the lower the premium.

Q—In the event of a claim involving a fleet vehicle, what does the HCA have to do? Whom do they report to? Does the Health Care Protection Program (HCPP) get involved?

The HCA fleet coordinator reports all accidents directly to ICBC. If a claim is over the primary auto liability insurance limit provided by ICBC, then coverage under HCPP is triggered. HCPP provides excess liability coverage on vehicles owned or licensed in the name of the HCA. (e.g. minimum ICBC requirement for regular size vehicles is $200,000 and $1,000,000 for large vehicles; HCPP's excess auto liability policy would respond over each of these compulsory limits). HCPP also provides physical damage coverage on vehicles owned or licensed by the HCA subject to a $10,000 deductible.

In addition to reporting claims to ICBC, HCAs should report to HCPP any accidents where serious injury to third parties has occurred or where physical damage to the HCA vehicle has been sustained. It is important to notify HCPP as soon as possible after an accident. HCAs should not wait until ICBC coverage is exhausted to report such incidents to HCPP.➤

Claims Abstract— Post Operative Driving After Anaesthetic

Background: This abstract arises from the discharge of a patient from a surgical day care following a minor procedure under a general anaesthetic. This case is similar to many situations that occur frequently when patients are discharged after a procedure under a general anaesthetic or other forms of sedation or anaesthesia.

Mr. B was scheduled for a minor procedure in the operating room of a medium-sized regional hospital. He lived in a town some distance from the town the hospital was located so he was unable to attend the hospital for pre-op teaching and preparation however his surgeon's office had provided the standard written instructions for pre-op and post-op care including discharge instructions. The instruction sheets advised him he was not to drive for 24 hours after his surgery and he should have a responsible adult pick him up and drive him home from the hospital and to stay with him overnight. He was

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Claims Abstract *(continued from page 3)*

advised that he should not take a taxi home without a responsible adult with him at all times.

Upon arrival in the surgical day care unit, he was admitted and answered the usual questions about what he was going to have done that day and did he have any allergies. He was also asked how he planned to get home after discharge. He said he had driven his truck to the hospital and left it in the parking lot, but that his friend was going to come by and drive him home and that his wife would be at home to care for him in the evening.

Mr. B's procedure was uneventful as was his recovery from anaesthesia. He was fully oriented, his vital signs were normal and stable, he tolerated fluids well and after the required amount of time of bed rest he mobilized without difficulty. He was steady on his feet as he walked to the washroom. His speech was clear and conversation appropriate as he chatted with nurses while he ate a light snack. He said he was glad to have had a day of rest as he had worked late the evening before to complete a job he was working on. His nurse asked him how he was getting home and if she could call his wife or someone to come and get him. He said he would call his friend on his cell phone and that he would be okay. His friend could come shortly and that he would wait by the truck for him to arrive. The nurse advised him that he was not to drive after his anaesthetic and that he was not to drive himself home. She suggested he wait on the unit until his friend could arrive and accompany him to his vehicle. Mr. B became quite angry and said he would call his friend, he was not going to drive and that it was none of the nurse's business. He appeared to make a call on his cell phone and was overheard asking his friend to come and meet him. He told the nurse he was going to have a smoke outside and wait for his friend there. He then left the unit.

An hour later, Mr. B's truck was found in a ditch. It had left the highway and rolled several times. Mr. B was the only occupant and he was later diagnosed with a brain injury and severe fractures to both legs and right arm. The investigation concluded that he had fallen asleep while driving the two hour trip home.

The Allegations: Mr. B claimed that the physicians and nurses were negligent in discharging him too early following his procedure and did not take appropriate action to stop him from driving his vehicle when they knew or ought to have known he should not be driving within 24 hours of a general anaesthetic. Mr. B was now unable to work at his previous occupation and would be unable to provide for himself, his family or pay for the care he now required for activities of daily living.

The Outcome: Mr. B retained legal counsel and commenced legal action against the health authority and the physicians involved in his procedure. The investigation undertaken by the health authority determined that standards established by hospital's policies and procedures had been followed correctly by all the employees. It was confirmed that the information brochures, prepared by the health authority, were given to Mr. B by the surgeon's office and he was told by the surgeon's receptionist that he must arrange for an adult driver to drive him home and for an adult to stay with him at least until late evening of the day of his procedure, preferably overnight. Mr. B was observed to have these brochures with him when he arrived at the hospital. The review of the chart determined that Mr. B met the criteria for discharge as set out by the surgical committee. He was alert and fully oriented with stable vital signs within normal limits.

The charting done by the nurses in the surgical day care was detailed and precise. The conversation with Mr. B regarding his arrangements for a ride home was documented in detail and this was very helpful as it confirmed that he was asked for his assurance that he had a ride home and that he had stated he had made arrangements even though, as it turned out,

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He told the nurse he was going to have a smoke outside and wait for his friend there. An hour later, Mr B's truck was found in the ditch. The Investigation concluded that he had fallen asleep while driving the two hour trip home.

Claims Abstract *(continued from page 4)*

he did not have an adult driver and escort. He stated he was not going to drive his truck. The high quality of the documentation presented a clear record of Mr. B's time in the surgical day care and the events leading up to the time he left the hospital.

During the interviews with the nurses, it was apparent that the nurses were very aware of their obligation to assess the patient and, if the patient was not deemed to be competent to drive and the patient was insisting that he or she would indeed drive in spite of the risk to themselves or to the public, to call the police after advising the patient that this is what would happen if they got in their vehicle. The nurses knew they could not forcibly take the keys of the vehicle away or restrain the patient but the protection of the public was paramount and was not a breach of confidentiality or privacy of the patient. The nurses confirmed that had Mr. B stated he was going to drive his truck home and they had determined that he was unsafe to drive, they would have called the police.

Further investigation revealed Mr. B had been working very long hours in the week prior to his procedure and he had had only four hours of sleep the night before his procedure. While he had told the nurse that he had worked late in the evening, he did not disclose he had worked late into the night and was extremely sleep deprived. The investigating police officers reported the cause of the accident was due to the driver falling asleep at the wheel and not due to impairment by drugs. Unfortunately, Mr. B was the author of his own misfortune. He was a competent adult fully capable of managing his own affairs and he chose not to comply with the instructions and advice he received from his health professionals. Even though he had been advised several times not to drive himself home and he was given the information in plenty of time to have made appropriate arrangement, Mr. B chose to drive his truck home. Mr. B eventually withdrew his civil suit against the health authority and the physicians when the evidence did not support his claim of negligence on the part of the health authority, its employees or the physicians in charge of his medical care.

Lessons Learned: This abstract emphasises the importance of compliance with standards as set out by professional bodies and policies and procedures and protocols established by the health authority. The admission and discharge protocols were followed without exception. Information was provided as required. The documentation completed by the registered nurses complied with the standards developed by the College of Registered Nurses of BC. The chart clearly showed the standard of care had been met by the nurses and the physicians.

Had the documentation not been complete, it would have been much more difficult to prove that the standard of care had been met. The nurses charted the information they gave to Mr. B. They stated what they had told the patient "Patient advised that he must not drive for 24 hours following a general anaesthetic and he was asked what arrangements were made for his trip home". They charted the response "Mr. B told me that he had driven his truck to the hospital but his friend would come and drive him home". The charting was done in a timely fashion and the entries were clearly marked as to time. Had the charting not been precise and timely the patient could have alleged he had not been told and that he had not said he had a drive home.

Without evidence to the contrary, the courts will usually accept the evidence of the plaintiff patient. It can take several years for cases to come to trial. Documenting what was said and when avoids having no memory of events that may have occurred up to five years ago and also avoids the suggestion that late entries or seemingly random entries were added at a later date or time to cover up negligent care. Good documentation and compliance with policies and procedures provided good evidence the nurses provided quality care in this instance. ➤

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Hospital Corners— Quick Risk Tip

What to do When Faced with a Property Claim

The holiday season is upon us and the new year is just around the corner which makes it a great time to review some of the basics of filing property claims. The simplest starting point when faced with a potential claim is to consider the following;

- Is the property covered?
- Is the event that caused the loss covered?
- What exclusions, if any, may apply?

The severity of the loss should be the deciding factor for your response. The very simple and low value claims that fall well below the deductible of $10,000.00 should still be reported, but the health authority can use its own discretion on how to address the issues. On the other hand, any complex claim, or losses that exceed the $10,000.00 threshold, will require involvement of the HCPP claims team.

It is imperative that we be notified as quickly as possible for all types of claims. Email or fax is generally preferred for the smaller claim submissions, but for a severe water or fire damage event please call the claims examiners immediately. Failure do so might prejudice our ability to determine cause, extent of related damages, and to ensure proper steps are being taken to minimize further damage and costs. If our position is prejudiced, your claim may be prejudiced as well.

Do not hesitate to initiate emergency clean up or bring in accredited restoration services as the first 48 hours are the most critical when addressing water damage. The sooner the better is always the best rule of thumb, don't wait for us!

If it's a major loss, such as a major fire or water event, and it's after hours, you can call our main line for emergency contact of on-call examiner 250-356-1794.

For the smaller, less complex claims, there may be some things you can do which will assist in the processing of your claim. The more information you have available, the more efficiently the HCPP team can help you to bring your claim to completion. Here are examples of the type of information that may be requested after you have submitted your incident report to HCPP:

- What was damaged? Is this property owned/ leased by the health authority?
- How did it occur? Damage by water, fire, theft, explosion, etc.
- When did it occur?
- What is the estimated cost for repairs to damaged property?
- Have photos of the damages been taken to support the claim file?
- Is there a known responsible party that has caused the damages? The information will be utilized for possible recovery of costs.
- Is there involvement of local law enforcement? Police detachment, file number, and name of constable should be available upon request where applicable.
- Have steps been taken to preserve the evidence? An adjuster/engineer may need to view a damaged item/equipment/machinery to be able to build a case for recovery of costs.
- Have you begun to gather supporting documentation for your claim? For example:
  - Original acquisition receipts
  - replacement receipts
  - repair quotes/invoices
  - building material invoices
  - summary tracking of labor costs

Our mandate is to work collaboratively with you to meet a common goal. The claims examiners are readily available to answer your questions and are focused to return you to pre-loss condition at minimal cost. We understand the timelines and urgency of your needs, and will endeavor to assist you accordingly.➤

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Darren Nelson
Assistant Claims Examiner

Automatic Sprinkler System Considerations

The National Fire Protection Agency (NFPA) in the United States has been keeping records of fires and their causes for some time. Using these records the NFPA has developed statistics on the effectiveness of sprinkler systems and the causes when these systems have not been effective.

Automatic sprinkler systems are an effective way to protect buildings from the threat of fire. When a fire breaks out in a building with a high fuel load (paper, furniture, etc) temperatures can reach the point where most materials (fuel) will spontaneously combust in 6-10 minutes. As the response time for most fire departments is 6-10 minutes you can see that in many cases a fire will be well established by the time the firefighters are able to start their work. This time line reinforces the importance of an automatic sprinkler system that will activate well before temperatures reach that critical point. What follows are some common mistakes that could severely impede a sprinkler system's effectiveness and result in a major loss.

The sprinkler system fails to operate. In two thirds of cases where a sprinkler system failed to operate it was due to the system being shut off when the fire occurred. It is not unusual for a sprinkler system to be shut down for maintenance, upgrades or repair, but it is essential that the system is returned to service after shutdown. Poor maintenance attributed to another 11% of system failures making human error responsible for more than 75% of the cases in which sprinkler systems failed to operate.

To aid our clients in ensuring that systems are not left non-operational after maintenance, HCPP operates a fire impairment notification program to serve as a reminder of steps to take both prior to shutting down a system and upon completion of work. Information on the HCPP sprinkler impairment notification program was published in the 2009 Spring/Summer edition of *Handle with Care* and is available here.

In 2006, the NFPA reported that when sprinkler systems do operate they are 96% effective at extinguishing fires. For the remaining cases that were not effective, water did not reach the fire 55% of the time. Thirty eight percent of systems that failed to release enough water failed due to system damage, and a further 2% of systems had the water turned off before the fire was extinguished.

If we assume that the sprinkler system was designed and installed correctly to provide appropriate coverage, why do we experience any losses as a result of water not reaching the fire? Obviously something has happened that interferes with the system's ability to cover a room when it is activated. One common item noted in the loss control inspection reports is that items are stored too close below the sprinkler heads. The minimum distance that is required in order for a sprinkler to create its' full spray pattern and ensure complete coverage of the space is 45cm (18 inches). It is essential to maintain this distance below the sprinkler for it to be effective.

Consider inspecting your storage areas on a regular basis to ensure that the sprinkler heads are clear and unimpeded. This is particularly important if rooms are accessed by multiple people who may not be aware of the dangers of stacking material too close to the sprinkler head. Additionally, it may be useful to post an appropriate warning sign outside rooms where this is could be a problem.

Another common item that is reported in loss control inspection reports is missing ceiling tiles. This is important to the sprinkler head's operation as a missing ceiling tile will allow a fire's heat to rise above the dropped ceiling and delay the heat build-up at the sprinkler head (delaying activation). The more time a fire has to build before the sprinkler head activates, the less likely the sprinkler system will be able to control the fire. Therefore, it is important that any time ceiling tiles are removed they be replaced again as soon as possible so that the sprinkler system will function as designed.

Sprinkler systems are an effective way of protecting our people and buildings from fire. However, it is important to remember that when a sprinkler system is interfered with it is less likely to operate properly. We can mitigate these risks by taking a few simple steps to ensure that our sprinklers will perform as designed.➤

Dave Foxall
Risk Mitigation Consultant

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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