Handle With Care

Volume 5, Issue 1 **Summer 2008**

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

In this Issue:

Please feel free to copy and distribute as necessary.

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Health Team Leader's Message

In this issue of Handle with Care, you'll find the first of a regular ***Claims Abstract*** feature. As part of our goal of focusing on the "value-add" that HCPP brings, we are committed to abstracting at least one claim per newsletter. The format will generally include the background of the file (or files where it makes sense to group them together), the issues or allegations raised, the outcome from a claims/litigation management perspective and finally a discussion of the relative risk management issues present as well as questions to consider/resources to reference. HCPP will also be looking at other ways to disseminate learnings from our files recognizing the unique opportunity we have given our broad provincial vantage. Also on the topic of shared learnings, ***Defamation and Jurisdiction*** looks at the issue of the court's jurisdiction over disputes that are covered by a collective agreement that mandates a conclusion by arbitration. The cases discussed actually take place in the education sector, however they are equally relevant in the health sector. ***Reverse osmosis machines, construction*** and ***employee fidelity*** issues are discussed in this newsletter along with information on HCPP's work with the Practice Education Collaborative of the BC Academic Health Council on the modernization of the ***academic affiliation agreement*** template and an old children's nursery rhyme is brought into the twenty-first century with ***Don't Let the Bed Bugs Bite***.

A wrap up of the Risk Management Branch's ***conference*** "Navigating the Labyrinth: Practical Risk Management Solutions for a Complex World" is included with information on the location of handouts. Mark your calendars for the next Risk Management Branch conference scheduled for April 2009 in Victoria at which HCPP will hold a pre-conference workshop specifically designed for HCPP members.

Finally, 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

Risk Management Branch Conference

The Risk Management Branch successfully hosted its first conference, "Navigating the Labyrinth: Practical Risk Management Solutions for a Complex World" . The conference was attended by 275 participants including clients from across all programs within Risk Management Branch.

The conference provided information for understanding and utilizing risk management principles, including information sessions on How to Build a Successful Business Continuity Plan, Managing the Threat of Violence and a mock trial outlining the points of a negligence trial from a recent case along with many more.

We would like to thank all the guest speakers and all the participants that made the outcome a complete success and greatly exceed our expectations! We look forward to seeing you all again for our next Conference scheduled for April 16 – 17, 2009 at Delta Ocean Pointe in Victoria.

For your information program handouts from this conference can be found on our Web Site: www.hcpp.org

Indemnification and Insurance Provisions for CCDC 2 - 2008

The Risk Management Branch (RMB) is the central agency responsible for providing risk management and insurance advice and direction to ministries and the broader provincial public sector. RMB has recently completed negotiations with representatives from the construction industry including architects and engineers to develop indemnification and insurance terms for the new Canadian Construction Document Committee Contract CCDC 2—2008, the recommended form of contract for new construction and/or renovations. RMB has also arranged an owner-controlled course of construction and wrap-up liability insurance program (the "Program") for the provincial public sector including Crown corporations, the health and education sectors as well as ministries.

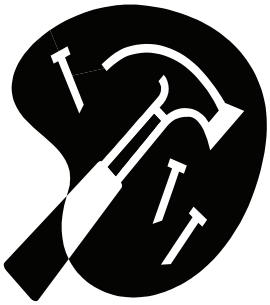
For health, **all construction projects greater than $1,000,000 in value must be reported to HCPP**. HCPP will ensure the insurance coverage is placed in accordance with the Program. Projects less than $1,000,000 should usually be insured by the contractor, except in those cases where there are high-hazard or unusual exposures. Please refer to HCPP for guidance.

Reporting construction projects to HCPP is critical in managing the risks of construction as well as those in the procurement and contracting stages. HCPP will maintain a construction project registry in coordination with the Health Care Agencies (HCAs) and the Ministry of Health to ensure that coverage is placed such that no projects go uninsured, underinsured or insured inconsistently with the Program.

The indemnification and insurance terms negotiated by the RMB are available at the following link http://www.fin.gov.bc/PT/rmb/construction.shtml

For information regarding the CCDC 2 - 2008 document and Supplementary Conditions, please visit the Public Construction Council of British Columbia web-site at http://www.pccbc.com.

If you have any questions about a particular construction project, please contact Jeffrey.Milne@gov.bc.ca ➤



Advancements in Affiliation Agreements

Health Authorities are well aware that adequate recruitment and retention of qualified health care personnel is one of the critical risks facing their organizations today. Shifting demographics mean more health care professionals are retiring at the same time that demands for their services from an aging population are increasing.

The development of future generations of health care professionals is fundamental to the continued delivery of quality health care. The Practice Education Collaborative of BC PECbc), a working group of the BC Academic Health Council, with representation from the six provincial health authorities and the BC post-secondary education sector developed resources to help health and education partners formalize their relationships and clarify their practice education roles and responsibilities. Visit the Health Sciences Placement network at http://www.hspcanada.net/index.asp for a complete view of what has been accomplished to date including standard guidelines and recommendations for managing practice education placements.

While individual relationships between staff of the authority and the educational institution are important, formal written agreements are needed to ensure a partnership that extends beyond the tenure of those relationships and defines the

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Advancements in Affiliation Agreements *(continued from Page 2)*

responsibilities of each partner. With this objective in mind, one component of the PECbc project was an initiative to standardize and modernize the academic Affiliation Agreement template.

The Health Care Protection Program (HCPP) and the University, College & Institute Protection Program (UCIPP) both participated in this initiative by contributing to an affiliation agreement sub-group of the PECbc project. We provided input into the insurance and indemnification language and facilitated the approval of the indemnities by the Executive Director of the Risk Management Branch as required under the *Financial Administration Act*.

Visit our website under What's New to read our Risk Note on Affiliation Agreements and to view a complete copy of the provincial template developed and released as part of the PECbc project.

Standardized and well coordinated structures within the practice education environment are essential to managing the risks associated with student placements. Each health authority needs to define its internal structure for managing affiliation agreements and for overseeing student practice education. A standard affiliation agreement is just the first step in the development of this structure.➤

Reverse Osmosis Machines and Subrogation

Subrogating is a common practice for all those who indemnify others for losses (such as insurance companies). The term subrogation applies to situations where one party takes on the legal rights of another party whose debts or expenses have been paid. For example, subrogation occurs when an insurance company that has paid to compensate its injured claimant takes the legal rights the claimant has against the party that caused the injury, and sues that party. Usually the insurance company is only interested in recovering what they have paid out. HCPP differs from other insurance companies because we will sometimes take actions to assist our member organizations in proactively recovering amounts which are not part of an insured loss.

In 2007 HCPP discovered there was a trend when six water damage claims were reported by member organizations involving reverse osmosis machines. Through an HCPP investigation, the cause of the damage was determined to be a design defect in the hand tightened compression joints.

Water damage resulting from this failure is covered by HCPP but the defect or any substantial costs to correct such a failure are not covered under the program. Water damage or system problems are not always evident so we recommend all member organizations having this type of system complete an inspection for this failure. HCPP was made aware recently that one of our member organization's facility managers was looking to replace their entire reverse osmosis system and discovered the joint problem only upon opening up some walls in preparation for the estimate. There was no prior visible water or structure damage.

HCPP is currently exploring recovery avenues (for both our and our member organization's costs) in this matter so we ask that all facility managers having such a system contact:

Blair Loveday, Senior Claims Examiner (250-952-0841 or Blair.Loveday@gov.bc.ca) to discuss how HCPP may be able to assist you in any potential recovery attempts. ➤

Riskwise Answers

What are the Health Care Agencies' obligations with respect to coverage where an employee is discovered to be responsible for a theft of money or property?

The HCPP Crime Coverage Agreement protects the HCA from most losses arising from the dishonesty of its employees. This encompasses both losses where an employee steals directly from the HCA and also third party coverage where the employee steals from a patient or client. Some losses are specifically not covered, such as those related to the emoluments of employment.

As with any other loss to property, following discovery, the HCA must take steps to establish the loss and to protect their property from further damage. The loss cannot be established solely through a shortage of inventory or a profit and loss comparison. There must be direct evidence of a crime having occurred and it must be reported to the appropriate authorities (police or RCMP). A forensic audit may need to be completed in order to prove the loss. The expense for this will be covered as part of the claim but only if it is incurred with the prior consent of HCPP.

The HCA must take steps to prevent further damage by doing what is necessary to protect the HCA's money or property. This may involve recovering keys, changing locks, cancelling company credit cards, removing electronic security passes or access codes, alerting others – to name a few. Once the employee has been discovered as the one responsible for an act of theft, the claim ends with respect to loss occurring beyond that point. The purpose of this is to ensure the HCA takes all steps in their power to ensure the crime ceases.

There is also an obligation on the part of the HCA to assist HCPP in obtaining restitution or otherwise recovering from the responsible person.

Employee theft is a difficult and sensitive issue presenting the HCA with multiple ethical and moral decisions. Where an employee is discovered to be stealing, and the HCA intends to make a claim for the loss under HCPP, early reporting of the claim is essential. ➤

Hospital Corners— Quick Risk Tip

Duplication and Separation of Data

A common risk control technique to reduce the impact on organizations of lost computer data is to make regular back-ups. How frequently back-ups are made depends upon the importance of the information and how often it is modified. Backing up once a week may be sufficient in many cases, but in others daily or even hourly back-ups may be required. It is important to consider that data can be lost for a variety of reasons such as corruption in the computer system or damage to the premises housing the system. It may be convenient to store back-ups at the same location as the computer system generating the information; however, this is of little value in instances where both the system and back-ups are vulnerable to loss (e.g. fire or water damage). To further protect the data, it is recommended that back-ups be separated from the original data and stored off site.➤

Defamation and Jurisdiction

Courts do not have jurisdiction to resolve all legal claims commenced.

Disputes between parties that are covered by a collective agreement that mandate a conclusion by arbitration cannot be litigated. If the dispute is covered by the agreement the court does not have jurisdiction to hear the matter, although the result of the arbitration is subject to judicial review.

Recent cases successfully argued before the Supreme Court of BC, although in an education environment, have applicability. In the first instance the plaintiff, a teacher, attended at a school while he was on medical leave. He was observed to be driving in an unsafe manner, using profanity and resisting security personnel. The police were called by the vice-principal who was concerned about the conduct of the teacher and the safety of the school premises. The police officer recorded that the vice-principal advised him that the teacher had been suspended due to misconduct with a student. The vice-principal vigorously denied he had made the statement. A lawsuit commenced against the vice-principal and the School Board for the allegedly defamatory statements made about him.

Counsel for the School District argued that the court did not have jurisdiction to hear this matter as the dispute was covered by a collective agreement between the British Columbia Public Schools Employers' Association and the British Columbia Teachers' Federation which mandates that issues between the employer and union members be resolved by arbitration and not by litigation.

After reviewing the relevant case law, the collective agreement and the *Labour Relations Code*, the court held that it had no discretion to hear the matter as the circumstances of the claim was covered by the collective agreement.

In coming to this conclusion, the court followed the Supreme Court of Canada decision of *Weber v. Ontario Hydro* [1995] 2 S.C.R. 929, where it was held that "mandatory arbitration clauses in statutes confer exclusive jurisdiction on labour tribunals to deal with all differences between the parties from collective agreements."

The court went on to adopt considerations from the Manitoba Court of Appeal decision in *Phillips v. Harrison* (2000) 196 D.L.R. (4th) 69, which identified when alleged defamatory statements may be considered work related and were to be "adjudicated pursuant to the alternative dispute mechanism". Defamatory statements may be considered work related when:

- the comments concern the employee's character, history, or capacity as an employee;
- the comments were made by someone whose job it was to communicate a workplace problem;
- the comments were made to persons who would be expected to be informed of workplace problems.

Applying these factors, the court held that the comments made, were of concern; they were made by the vice-principal whose job it was to communicate workplace problems and the comments were made to a police officer who would be expected to be informed of workplace problems. The claim was covered by the collective agreement and the court concluded it did not have jurisdiction to hear the dispute. The action was dismissed.

In the second case, the appellant commenced a legal action against the British Columbia Teachers' Federation, the Vancouver School Board, the principal and the physician, again alleging she had been defamed in the course of her employment.

As a result of a complaint, it was determined that a school teacher employed by the Board should be examined by a physician. The school teacher saw a psychiatrist and the psychiatrist concluded that the teacher was unemployable. This teacher went on medical leave and the benefits were ceased when the teacher refused psychiatric treatment. The trial judge reviewed the

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Defamation and Jurisdiction *(continued from Page 5)*

decision of *Weber v. Ontario Hydro* and concluded that the allegations made were within the collective agreement and must be resolved by an arbitrator. The teacher appealed the judge's findings to the Court of Appeal and argued that the use of the school medical officer was outside the collective agreement and therefore the "dispute no longer arose from the interpretation, application, administration or violation of the governing collective agreement".

The Court of Appeal held that the essential character of the dispute was an unworkable atmosphere which was contemplated by the collective agreement. The court held it had no jurisdiction to hear the matter and it could not be said that pleading the issue as a tort took the dispute outside of the collective agreement. The appeal was dismissed.

Although most claims dealt with by the Health Care Protection Program involve bodily injuries suffered by patients or visitors to hospital premises, the Claims and Litigation Management department of the HCPP has expertise to deal with all manners of legal proceedings that are brought against hospital personnel, including defamation allegations by employees.

Should you have any questions regarding what types of claims are covered by HCPP or need advice about potential legal actions that might be brought against you or your organization, the HCA's risk manager or chief risk officer should be contacted.➤

Claim Abstract

Failure to Monitor / Take Appropriate Action / Human Rights

Background: The patient had a history of generalized anxiety disorder, depression and drug and alcohol abuse but, other than an antidepressant, had been considered drug free for a number of years. The patient presented one morning at the hospital emergency room complaining of ongoing pain and vomiting over several days. The emergency physician diagnosed pneumonia and the patient was admitted to the Monitored Care Unit (MCU) with morphine, gravol and antibiotics prescribed. The patient generally maintained good oxygen saturation while in MCU, but oxygen was applied during the second night. During this time, the patient also appeared anxious, indicated pain and desired to smoke a cigarette. By the next morning, oxygen saturation was good and the attending physician felt vital signs had stabilized. Later that morning, a chest x-ray was taken and the patient was transferred to the general ward. The patient was stable, yet weepy, agitated and communicating in a whiny voice upon arrival at the general ward. A review of the x-ray that afternoon showed adverse internal change. The worsening condition was noted by the attending physician and discussed with the radiologist, internalist and incoming physician, who also noted the patient was coughing and oxygen retention had decreased. As the afternoon progressed, oxygen levels continued to decrease and the patient remained agitated, often removing the oxygen mask. Tylenol 3 was administered. By late afternoon, oxygen saturation levels were at 57% and patient was extremely agitated. The attending physician saw the patient, noted that the patient was "medically stable" and transfer out of the general ward was not necessary. Four and a half hours later, the patient's pulse was 131 and oxygen levels had again dropped to 57%. A code blue was called 5 minutes later as the patient suffered respiratory arrest and cerebral anoxia. The code blue team arrived and the patient was intubated and ventilated. The patient was transferred to emergency and then to ICU, where the medical condition continued to decline. Death was pronounced the following morning.

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Claims Abstract *(continued from Page 6)*

It is important to note that the patient, family and friends attempted to communicate concern for the patient's declining state to hospital staff throughout the stay.

The Allegations: Loss allegations arose largely out of a breakdown in communication and failure of the attending physicians and nursing staff to respond to or take seriously indications of the patient's deteriorating condition, particularly in light of persistent advocacy on behalf of the patient. This formed the crux of human rights and ombudsman complaints by the patient's mother, raising questions about the treatment of individuals believed to be drug addicts. To the ombudsman, she alleged unfair procedure and unreasonable responses to her questions about the circumstances of the death and requests for documents. She also made an application to the Human Rights Tribunal alleging denial of service due to the mistaken belief that the patient was a drug addict. A coroner's investigation was also launched.

The Outcome: The complaint to the Human Rights Tribunal was dismissed due to case law which established that a claim may not be made on behalf of someone who is already deceased at the time of complaint.

The hospital responded to the ombudsman's complaint by indicating that many of the documents requested by the mother did not exist or had not been promised. As well, hospital staff had met with her on more than one occasion. This complaint was set aside mainly because the coroner's investigation was already underway.

The coroner's report found that the patient had died of anoxic encephalopathy due to ARDS and Group A Streptococcus pneumonia. The report was quite critical and gave recommendations to the hospital and relevant professional colleges concluding that inadequate monitoring and reporting by staff had contributed to the patient's death.

Risk Management Issues: The major risk issues relate to the standard of care the patient received and whether monitoring, reporting and response of the medical staff was sufficient. Most noteworthy:

- *Communication between medical staff* - although hospital records indicate some communication took place, the lack of action indicates the seriousness of the patient's condition was not properly communicated or acted upon.
- *Failure to receive adequate monitoring* - the general ward was too busy to provide adequate monitoring of this critically ill patient.
- *Response to deteriorating medical condition* - despite very low levels of oxygen and continued agitation, the patient remained on the general ward until respiratory arrest occurred.
- *Documentation and timing of code blue* - while hospital records later indicated a quick response to the code blue call, inconsistencies in the charting and times entered led to confusion and concern by the coroner and the patient's mother.

Other risk issues identified include:

- *Treatment of Patients with Addictions* - the human rights complaint arose from the mother's belief that the patient had been discriminated against on the basis of a history of addictions. Staff should be careful not to make assumptions and be aware of sensitivity in these circumstances, giving careful consideration to statements or comments which could be misinterpreted.
- *Communication with Family Members* - the patient, family and friends all expressed concern at times about medication and care, often feeling they were ignored. After the death, the mother felt she was being denied information despite many meetings with hospital staff. Misunderstandings could have been relieved to a certain extent by consistent messaging throughout the various meetings.
- *Documentation* - The coroner's report was in dispute with hospital records in several areas due, in part, to discrepancies in the evidence provided by nursing staff and inadequate charting.

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Prompt response to the coroner's recommendations and the ombudsman's questions resolved concerns; however, appropriate documentation could have avoided some issues from ever being raised.

The Hospital's Response: The nature of the coroner's report and the hospital's own internal investigation led to prompt reaction from the hospital. Work forms were developed to better manage maintenance of oxygen levels and doctor's orders for community acquired pneumonia. Nurses received training to update skills in respiratory assessment and care of deteriorating patients, including a review of emergency procedures and the implementation of flow sheets for patients requiring close observation.➤

"Don't Let the Bed Bugs Bite"

Everyone is likely familiar with the childhood nursery rhyme "sleep tight and don't let the bed bugs bite" but what do you do when the bed bugs are in the hospital beds and they are biting the patients? Do you have protocols for dealing with bed bugs? Are you taking proactive steps for identifying bed bugs before they become an issue?

Bed bugs are making a come back. International travel and a ban on the pesticide DDT have resulted in an increased incidence of bed bugs; in some areas bed bugs have reached epidemic proportions. They have been found in many areas accessible by the public, including hospital waiting rooms and nursing homes. Lawsuits are becoming more common, with a number of lawsuits launched against various hotels and residential building owners, including some posh ones in London and New York City. While most are settled before going to trial, some have had very large damages awarded by the courts. In addition, reputation risks must be considered because of the social stigma attached to bed bugs.

According to Health Canada, a female bed bug can lay 3-4 eggs per day; the eggs are tiny, whitish and very hard to detect. Most adults live 10 months and can survive without feeding for 80 to 140 days. An adult bed bug is brownish and is 4-5 mm in length. Bed bugs commonly hide in mattresses, carpets, behind peeling paint or wallpaper, and in crevices in wooden furniture. The bugs are nocturnal and typically bite people while they sleep, usually just before dawn. Although bed bugs are not associated with the transmission of a health disease, the result of having bed bugs can be costly.

Consider this scenario: A patient is admitted to hospital and is assigned a bed, which unbeknownst to the hospital, contains bed bugs. The patient leaves the hospital and inadvertently brings the bed bugs home. The patient's residence becomes infested with bed bugs and a claim is made to rid the house of the bed bugs and replace all infested beds, furniture, clothing, bedding etc. It's easy to see how the cost of eradication could far exceed any claim for actual injury, embarrassment or anguish. Further, consider the outfall should the patient record the incident on an internet blog site or chat forum.

What can organizations do to protect themselves?

Many health authorities have policies for dealing with lice and rodents. Some have policies and protocols for treatment of bed bugs once they are detected (usually after someone complains of bites) but very few have early detection plans.

Health Care Agencies, particularly those in areas where bed bugs are making a comeback, may want to consider proactive measures to prevent infestation. All workers should be educated on how to detect bed bugs and health care agencies may want to consider contracting a pest control company to do random samplings of rooms for bed bugs. Housekeeping should notify their managers if they see any evidence of bugs or if they see conditions that facilitate insect infestation. Mattress encasings could be used on all beds; sleepers and chairs in a state of disrepair should be fixed or discarded so as to not harbour the possibility of bed bugs. ➤

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 Province 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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