Handle With Care

Volume 10, Issue 1 **Spring/Summer 2013**

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

Please welcome back our guest contributor, Brad Buck from the BC Public Service Agency. Brad follows up the article he submitted for our last edition with a second segment on ***WorkSafeBC.*** This time, a homeowners' perspective is shared.

All government organizations are subject to the *Freedom of Information and Protection of Privacy Act.* Have you ever wondered what implications this *Act* would have on meeting minutes? Read our ***Hospital Corners (Quick Risk Tips)*** section to find out.

A big myth is that creating a risk register is a time consuming and complicated process. We debunk that for you in our article titled ***Risk Registers are Easier than you Think.***

Consolidation has provided some great opportunities to standardize practices. Specifically, our ***Risk Wise Answers*** contains some very practical advice about lease agreements that has been developed while working with the Lower Mainland Facilities office, now reviewing leases for 4 separate health authorities. This central office is quickly becoming proficient in managing risk in lease agreements.

Our ***Claims Abstract*** deals with the Improper Stocking of Crash Carts and the unfortunate results of emergency measures that fall short in a critical time. Awareness is a first step in preventing such an occurrence.

Finally, we remind you there have been changes to the *Limitation Act.* What implications does this have for clients of HCPP? See ***Risk Buzz*** for answers.

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

Homeowners and WorkSafeBC

Do you own a Home? Yes.
Are you an employer? No.
*Are you **sure** you aren't an employer?*

Recently there have been some high profile cases involving home owners that highlight some little known parts of Workers Compensation Law in BC. As a homeowner (or even a renter that is having work done on your behalf) you may have some WorkSafeBC obligations that you didn't know about and that could have costly consequences.

WorkSafeBC (WSBC) administers the workers compensation insurance program that all employers pay into to ensure that any worker injured on the job receives any required medical treatment and/or wage loss benefits. The definition of "employer" under the *Workers Compensation Act* is very broad and includes home owners. If you are completing renovations, building a home or hiring long term help you may either need to register as an employer with WSBC or ensure that the company has WorksafeBC coverage.

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Homeowners and WorksafeBC *(continued from page 1)*

If you are hiring someone to work around your house for less than 8 hours a week or for a specific job that will be less than 24 person hours work, then you will not be required to register as an employer with WSBC. This covers situations such as hiring neighbourhood kids to look after your lawn or shovel snow for the season or having someone come in for a short, specific project like painting a fence. There is also an exemption for child care work for before/after school care for up to 15 hours per week

If you hire a worker for more than 8 hours on average a week, or for a larger project that will require more than 24 person hours, you should register as an employer with WSBC and you will have to pay premiums to WSBC based on the amount of wages you pay the workers. Note this applies when you are hiring individual workers (part time or full time), *not a company,* to do the job(s).

When you hire a *company* to work in or around your home, always ask them if they have WSBC coverage. Check their information by requesting an online clearance letter from WorkSafeBC before they begin work. Clearance letters can be quickly and easily obtained by going to: http://www.worksafebc.com/insurance/managing_your_account/clearance_letters/default.asp

It is vital to ensure the company you hired has WSBC coverage, and continues to have coverage for the duration of the project. If a worker of the company sustains an injury you may be responsible for the cost of the accident (medical treatment, wages, etc.) if the company does not have current WSBC coverage; or you may be responsible for paying the premiums of the company.

There is also an advantage to ensuring that you or your contractor has WSBC coverage: it removes the right for an injured employee to sue for damages. They can only make claims under the no-fault *Workers Compensation Act*, limiting your liability.

If you are having work done where there will be multiple contractors on site, you are building your own home or have situations where one contactor may affect the safety of another contractor at your house, you may require a "Prime Contractor" under the *Workers Compensation Act*. If a Prime Contractor is not designated in writing the role defaults to the owner, YOU!

The role of a prime contractor is to coordinate safety activity on the worksite and establish a system or process that will help ensure compliance with the *Occupational Health and Safety Regulation*, not something the typical home owner wants to try and take on.

In most cases on a large job with a general contractor and multiple trades on site, the general contractor will be the Prime Contractor. But you must ensure that you designate the Prime Contractor in writing, so ensure it is in the building contract, either attached in a schedule or memo signed by both parties.

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WorksafeBC Resources to Help Homeowners

- Renovating and building homes: http://www.worksafebc.com/publications/how_to_work_with_the_wcb/Assets/PDF/homeowner.pdf
- Clearance Letters: http://www.worksafebc.com/insurance/managing_your_account/clearance_letters/default.asp
- Hiring Contractors Bulletin: http://www2.worksafebc.com/i/posters/2005/WS%2005_05.htm
- Prime Contractor Information: http://www2.worksafebc.com/publications/ohsregulation/Policies-WorkersCompensationAct.asp#SectionNumber:D3-118-1

Homeowners and WorksafeBC *(continued from page 2)*

As a home owner, you can 'accidently' be a Prime Contractor if you hired different companies to be at your home at the same time. For example, you hire an exterior painting company and a company to fix your deck and they are on site at the same time. These two companies may affect each other's safety and will require a Prime Contractor to coordinate. In this case approach one of the companies and ask them to be Prime Contractor (and designate it in writing) or simply schedule the companies to be there on different days.

It is also possible to require a Prime Contractor even if the two companies are not on site at the same time but will affect each other. This tends to be the case on complex and high risk projects, so it is best to ensure a Prime Contractor is designated and if you have any doubts contact WSBC's Prevention Department.

If you are acting as your own Prime Contractor, you may want to contact the Employers' Advisers Office who provide free, unbiased advice about safety, claims and dealing with WSBC: http://www.labour.gov.bc.ca/eao/

One final item, condominium strata owners have the same obligations as home owners (and a few more). If you are involved with the strata, best to ensure the strata is asking for WSBC coverage from any contractors on site. Otherwise your strata's reserves could be paying for a workplace injury.➤

Brad Buck, CRSP
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BC Public Service Agency

Risk Registers are Easier Than You Think

Most organizations today are subject to some form of risk management reporting requirements. Health Care Agencies (HCAs) are no different and will have their own internal policies governing what they report, how often and to whom. For example, an HCA may be obligated to compile and report annually upon corporate-level risks including the status of proposed mitigations.

Whatever the HCA's internal requirements are, meeting them does not need to be onerous. Completing a risk register is easier than you may think. We recommend the HCA does a bit of preparation first, using one of these two methods:

1. Identify risks associated with the achievement of the goals and objectives of the service or business plan; ask the applicable areas: "What might stand in the way of us delivering on this goal/objective?"

2. Ask each area to identify their most critical programs, services, or deliverables, and for each of those, identify what they are most worried about.

Either method should generate a list of possible risk events – uncertainties that might affect the strategic goals of the HCA. From there the risk management process builds on what you already know: what it is you're in business to do.

The process can be reduced to the following questions:

- ☑ What are our Goals, Objectives, Milestones, and Critical Paths?
- ☑ What **EVENTS** might prevent their achievement?
- ☑ What might **CAUSE** those events?
- ☑ What might the **IMPACTS** be?
- ☑ What are we doing about it now?
- ☑ Is that enough? Are we comfortable with that?
- ☑ If not, what else should we do?

Completing a risk assessment and compiling the accompanying risk register is a relatively easy process and should not consume a lot of time or resources. Once established, a quick update of the risk register at key meetings or during key reviews throughout the year is all that's required to effectively manage risks on an ongoing basis.

All HCAs are welcome to contact our office for assistance with your risk assessments: HCPP@gov.bc.ca➤

Claims Abstract—Crash Carts: Checking, Stocking and Liability

A "crash cart" (sometimes referred to as "emergency cart", "code cart", "resuscitation cart" or "code blue cart") contains the equipment and medication to deal with life threatening emergencies such as cardiac or respiratory arrest. The contents of crash carts at hospitals are determined by appropriate personnel, with the hospitals being generally responsible for maintaining and stocking them. The importance of checking and stocking crash carts cannot be overstated. But what can hospitals do to ensure crash carts are properly stocked and accessible when they are needed? And do physicians performing procedures have any responsibilities here? In the claim discussed below, the stocking and maintaining of the crash cart emerged as a central issue.

Background

Mr. A, a teacher with a wife and two young children, was scheduled for a medical procedure to be performed by Dr. B. The procedure was one that is routinely done, and Mr. A was to remain conscious throughout. But there was a very remote possibility of serious complications, including a reaction to medication leading to cardiac or respiratory problems. After discussing these risks with Dr. B, Mr. A chose to proceed.

The procedure was conducted by Dr. B in the hospital's treatment room. During the procedure, Mr. A began to feel nauseous and lost consciousness, with no detectable pulse. Dr. B immediately started resuscitation and began doing chest compressions. Upon hearing his shouts for assistance, hospital staff rushed the nearby crash cart into the treatment room, and assisted as best they could even though they did not have emergency response training. Dr. B decided to intubate Mr. A but the laryngoscope – which was needed to facilitate intubation - was not on the crash cart. Dr. B did have access to an airway and an Ambu bag, which he used. Staff located and brought in a laryngoscope from outside the treatment room, and Dr. B was able to proceed with the intubation. The delay in locating the missing laryngoscope was only a minute or so.

Unfortunately, Mr. A suffered hypoxia and died.

The Litigation

Under BC's *Family Compensation Act*, the family sued both the hospital and Dr. B for the wrongful death of Mr. A. Among the items set out in the claim were loss of care, guidance and affection, and also loss of financial support. The latter would involve consideration of the income Mr. A would have earned had he not died; this amount was significant.

Several issues were contested in the litigation. Did Dr. B and the hospital staff meet the required standard of care. If not, did the deficiencies cause Mr. A's death? The checking and stocking of the crash cart became of central importance. Dr. B felt the initial lack of a laryngoscope did not affect his ability to perform the resuscitation and, in any event, the hospital - not him - was responsible for any delay. The hospital took the position that Dr. B was at least partly responsible.

As is often the case, the experts did not agree. Dr B.'s legal counsel obtained an expert opinion that it was reasonable for Dr. B to assume the crash cart was fully stocked; his responsibility went so far as to ensure the crash cart was available, not to check its contents – that was the responsibility of the hospital. Another expert opined that the availability of emergency resuscitative equipment is also the responsibility of the physician performing a procedure, and that Dr. B's conduct here fell below the acceptable standard of care. There was also dispute regarding whether Mr. A would have experienced a better outcome had the resuscitation equipment been immediately available.

The case was eventually resolved by settlement, and did not proceed to trial.

Discussion and Lessons Learned

This matter highlights the generally accepted axiom of resuscitative medicine that "time is of the essence" and the longer adequate resuscitation is delayed, the worse the outcome for the patient; every second can truly make a difference.

Concerning the availability, checking and stocking of crash carts, hospitals clearly have obligations here. To start, hospitals should have policies in place requiring staff to check and stock crash carts both at reasonable intervals and after each use. A crash cart should also be secured with a breakaway plastic lock; an unsealed lock would prompt staff to thoroughly check and replace supplies, and then apply a new lock. Also, when checking a crash cart, staff should reasonably ensure all equipment and supplies are in order - for example, medications have not expired, the defibrillator is working, and supplies are not outdated.

In addition, hospitals should ensure policies are

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Claims Abstract *(continued from page 4)*

reasonably enforced and that staff know their role and responsibilities. Staff can be required to initial forms confirming the regular checking and stocking of crash carts. Checklists can also assist. Finally, hospitals should consider whether staff members expected to assist in resuscitation should have at least basic emergency response training.

The checking and stocking of crash carts is important to ensure patients faced with life threatening emergencies receive proper and timely medical attention. The consequences of not meeting our obligations can be very unfortunate for patients and costly for the health care system.➤

Kash Basi, BA, JD
Senior Claims Examiner/Legal Counsel

Risk Wise Answers - FAQ for Lease Agreements

Q - When should real estate managers send lease agreements to HCPP for review and approval of the insurance and/or indemnity clauses?

In accordance with the Guarantees and Indemnities Regulations to the Financial Administration Act all government corporations (which includes most Health Care Agencies) must have indemnities they grant approved by the Minister of Finance or the Executive Director of the Risk Management Branch of the Ministry of Finance. HCPP can facilitate this approval process for the Health Care Agencies (HCAs), but requires a copy of the contract in its final form prior to execution in order to do so.

A HCA must submit indemnities it is granting to other parties for approval. Indemnities granted ***to*** the HCA do not require approval, but HCAs can often benefit from risk management advice available from HCPP with respect to indemnities it receives.

Insurance is evidence that the indemnifying party has the financial ability to pay if the indemnity is invoked. It is an important component of a lease agreement and real estate managers should verify the insurance requirements for the Landlord are appropriate. Without the appropriate insurance, the HCA must rely on the financial strength of the Landlord to finance its indemnification obligations. There are also risks to the HCA if it agrees to insurance provisions that cannot be met by HCPP (for example, a waiver of subrogation). HCPP's Risk Note, Insurance & Risk Management in Lease Agreements outlines what type of insurance the Landlord and Tenant should carry.

Q - Do HCAs need to have HCPP immediately review all leases that had not been reviewed prior to signing for assessment /approval of the insurance /indemnity language?

No – HCPP will not generally provide a lease review midterm and indemnities must be approved prior to execution of the agreement. However, as leases come due for renewal it is good risk management practice to review the lease and determine if the terms and conditions are still suitable for the renewal term. This is especially important with leases that were originally executed years ago since the insurance language may be out of date, the indemnity may not have been approved or need revision and the HCA's legal counsel may want this opportunity to review and comment from a legal perspective.

Q - What is an indemnity? Is there a financial implication for the HCA?

An indemnity is a type of contractual risk transfer that is designed to mitigate the risk of one party causing loss or damage to another – it is a form of risk financing for the party receiving the indemnification. When Party A grants Party B an indemnity, Party A is saying it will reimburse Party B for any losses Party B incurs that arise out of acts for which Party A has agreed to indemnify. In other words Party A is making Party B whole again by putting Party B in the same financial position it was in preceding the loss.

Q - If an HCA is subletting or assigning the leased space does HCPP need to be informed?

Generally a sublease should follow the terms and conditions of the Head Lease. If the HCA is **not** granting the Sub-Tenant an indemnity, no formal approval is required. However, if the real estate manager has questions with respect to an HCA indemnity or how much and what type of insurance the Sub-Tenant should carry please contact HCPP.

Q – Does HCPP need a final signed lease for their files?

No – a signed copy is not required by HCPP.➤

Dragana Kosjer, CRM
Risk Management Consultant

Risk Buzz—The New *Limitation Act*

A new *Limitation Act*, SBC, 2012, c.13, (the "New Act") will come into force in British Columbia on June 1, 2013. Although the New Act makes some significant changes, we do not expect these changes will create much impact in the way the Health Authorities and HCPP currently manage potentially litigated claims. This article is a brief summary of the more important provisions of the New Act for information purposes only and is not meant to provide legal advice. If you have any questions regarding the New Act, or need advice about a specific claim, please contact HCPP.

The purpose of a limitation act is to set the time limits for when a claimant can file a lawsuit against a potential defendant. The New Act sets out a default time limit of two years in which to file a lawsuit. The two year limit will apply to any claim, unless the New Act specifically exempts the claim or another statute specifically exempts the claim. Similar to the current *Limitation Act*, the New Act provides a number of exempt claims. For our purposes, the important exemptions are:

1. A claim of sexual assault;
2. A claim of sexual misconduct (which does not amount to sexual assault) of a minor; and
3. A claim of assault and battery against a minor.

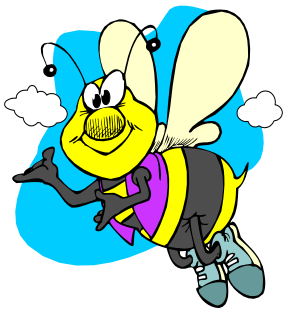
For these classes of claims, the New Act does not apply and as such there is no limitation period.

As does the current *Limitation Act*, the New Act incorporates the principle of "discoverability". That is, the limitation period does not start to run until the claimant knew or reasonably ought to have known that (a) the loss had occurred, (b) the loss was caused by an act or omission, (c) the act or omission was that of the person against whom the claim is being made and (d) a court proceeding is the appropriate way to seek redress. This is when the claim crystallizes. Unlike the current *Limitation Act*, the discoverability principle in the New Act applies to all claims, but it does not apply to the ultimate limitation period.

The New Act provides for special discoverability rules. The two most important for Health Authorities relates to minors and those persons under a disability. A person under a disability is an adult who is incapable or substantially impeded in managing his or her own affairs. In these cases, the claim is essentially not "discovered" until either the day the claimant, if a minor, turns 19 years of age, or, if disabled, the day the claimant ceases to be disabled, or when the claim crystallizes, whichever is later.

The ultimate limitation period is the absolute limit for making any kind of claim (except of course for those claims exempt from the application of the current *Limitation Act* or the New Act). Under the current *Limitation Act*, the ultimate limitation period is 30 years. However, under the current *Limitation Act*, the ultimate limitation period for tort claims (most commonly negligence) made against Health Authorities and medical practitioners is 6 years. Under the New Act, the ultimate limitation period is 15 years for all claims. This applies to Health Authorities and medical practitioners. No claim can be brought after 15 years, but a claim may be brought anytime before then, given the right circumstances. The discoverability principle does not apply to the ultimate limitation period. The ultimate limitation period commences to run from the time the act or omission occurs, not when the loss occurs or when the claim crystallizes.

As discussed above, under the New Act, the ultimate limitation period does not apply to those claims that are exempt from the New Act, such as claims for sexual assault. Also, the New Act provides rules for when the act or omission is deemed to have occurred, depending on the type of claim. For the claim of a minor, the day the act or omission takes place is the day on which the minor attains 19 years of age. For the claim of a person who is under a disability at the time the act or omission takes place, the act or omission is deemed to have occurred the day the person ceases to be disabled. In these cases, the ultimate limitation period starts to run from the date of the deemed act or omission.



Under the current *Limitation Act*, an acknowledgement of a cause of action or making payments on a claim prior to the expiry of the limitation period may reset the limitation period. Under the current *Limitation Act*, the ultimate limitation period of 30 years could not be reset. Under the New Act, even the ultimate limitation period of 15 years can be reset in this way.

Despite the fact the ultimate limitation period under the New Act could be as long as 34 years (in the case of an incident of negligence occurring at birth), this would be extremely rare. For adults, we expect the vast majority of litigated claims to be commenced within two years of being "discovered" and that the vast majority of claims will be discovered within a year or two of the incident. For minors, we would expect the vast majority of litigated claims to be commenced within two years of the minor turning 19 years of age.

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Risk Buzz *(continued from page 6)*

In compliance with other relevant legislation, such as the Hospital Act Regulations, and consistent with our Risk Note on Record Retention (September, 2009), we suggest retaining documents for adults for 10 years and for minors for 7 years beyond the minor's 19th birthday. Please refer to the Record Retention Risk Note for more details on records retention. This Risk Note can be found on our website at www.hcpp.org.

Of course, these retention periods only apply to those claims that have yet to be litigated. Once a claim is litigated and the litigation resolved, the file does not need to be retained beyond any applicable appeal periods.

For an incident that occurred prior to the New Act coming into force (on June 1, 2013), the question may arise regarding which limitation act applies. The answer to this question can be complicated. If you have a question about the application of the limitations acts to a specific incident, please contact HCPP directly.➤

Information from this article was drawn from the following sources: Briefing Note, Modernizing the *Limitation Act*: Bill 34-2012, (May, 2012) by Guild Yule; Insurance and Tort Liability Bulletin: Summary of BC's New *Limitation Act* (In Force on June 1, 2013) by Borden Ladner Gervais; and Ten Things You Should Know About British Columbia's New *Limitation Act* (October, 2012) by Jordanna Cytrynbaum and Angela Juba (McCarthy Tetrault).

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Hospital Corners— Quick Risk Tips

Meeting Minutes and FOI

Background

The *Freedom of Information and Protection of Privacy Act* (FOIPPA) was enacted to make public bodies more open and accountable by providing the public with a legislated right of access to records. FOIPPA applies to all records in the custody, or under the control, of the approximately 3,000 public bodies in B.C., including hospitals and health authorities.

Information must be released in response to an FOI request, except where: (i) one or more of the exceptions to disclosure specified in FOIPPA apply (these exceptions are set out in more detail below), or (ii) the release is prohibited by another statute which specifically trumps FOIPPA, such as *Evidence Act* section 51.

FOIPPA exceptions to disclosure are listed in sections 12 to 22.1 of the legislation:

- *Section 12: Cabinet and local public body confidences*
- *Section 13: Policy advice or recommendations*
- *Section 14: Legal advice*
- *Section 15: Disclosure harmful to law enforcement*
- *Section 16: Disclosure harmful to intergovernmental relations or negotiations*
- *Section 17: Disclosure harmful to the financial or economic interests of a public body*
- *Section 18: Disclosure harmful to the conservation of heritage sites, etc.*
- *Section 19: Disclosure harmful to individual or public safety*
- *Section 20: Information that will be published or released within 60 days*
- *Section 21: Disclosure harmful to business interests of a third party*
- *Section 22: Disclosure harmful to personal privacy*
- *Section 22.1: Disclosure of information relating to abortion services*

Meeting Minutes Specifically

Given the above, health authorities and hospitals must provide minutes of meetings to an FOI applicant unless the information can be withheld either pursuant to one or more of the FOIPPA exceptions to disclosure set out above (such as local public body confidences or harm to personal privacy) or pursuant to another statute which trumps FOIPPA.

To provide an idea of how disputes involving FOI requests for meeting minutes are decided, below are summaries of three matters considered by BC's Office of the Information and Privacy Commissioner (the "Commissioner's Office").

In the first case, PHSA was found to be partially

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Hospital Corners *(continued from page 7)*

justified in withholding from an FOI applicant, information from meeting minutes of a medical departmental staff committee. The information (such as medical information of patients, and employment history of staff and prospective staff) was withheld based on harm to personal privacy (FOIPPA, section 22) and *Evidence* Act section 51.

In the remaining two cases, the Commissioner's Office considered section 12(3)(b) of FOIPPA which essentially permits "local public bodies" (including hospitals and cities/municipalities) to withhold information that would reveal the substance of deliberations of their elected officials (or governing bodies) at meetings authorized to take place in the absence of the public (i.e. *in camera* meetings). The purpose of the provision to is to protect a public body's ability to fully and frankly explore issues.

In short, whether information in meeting minutes should be released to an FOI applicant, can be a complicated issue. Potential release under FOI should be considered when minutes are drafted. For further assistance, contact the FOI/privacy department of your public body.

The three matters considered by the Commissioner's Office (and referenced above):

Order F11-02 - Provincial Health Services Authority, and Children's & Women's Health Centre (CWHC) of British Columbia: A physician whose employment and hospital privileges at CWHC were suspended requested minutes of the meetings of CWHC's medical departmental staff committee. The Commissioner's Office found that section 51 of the *Evidence Act* applied to some but not all the withheld information. Section 22 of FOIPPA also applied to the medical information of patients and staff, and the employment history of staff and prospective staff (including evaluations of work, announcement of retirements and new hiring, the passing of exams and immigration issues). However, section 22 was found not to apply to the professional opinions that identifiable physicians expressed relating to the operation of CWHC.
(http://www.oipc.bc.ca/orders/917)

Order F12-11, **City of New Westminster:** A performing arts society requested records regarding assets located in a City-owned theatre. The City withheld two reports prepared for council and withheld portions of the minutes from two council meetings under section 12(3)(b) of FOIPPA. The Commissioner's Office found that section 12(3)(b) applied to the minutes of the *in camera* council meetings - but not to the reports as their release would not reveal the substance of council's deliberations.
(http://www.oipc.bc.ca/orders/952)

Order 00-14, **Inquiry regarding Vancouver Police Board in Camera Meeting Minutes:** An applicant sought access to minutes of *in camera* board meetings. The board withheld the entirety of responsive records under section 12 (3)(b). The Commissioner's Office found the board was entitled under section 12 to withhold only the substance of deliberations; the Board was not entitled to withhold portions disclosing meeting dates, times and locations, board members and others in attendance, or subject matter of meetings (although other exceptions to disclosure might apply – e.g. personal information must be withheld where protected by FOIPPA section 22).
(http://www.oipc.bc.ca/orders/582)➤

Kash Basi, BA, JD
Senior Claims Examiner/Legal Counsel

Did you know Fire Impairment Notices should now be reported directly to HCPP?

Under the HCPP Property Coverage Agreement, Section 12.1 Protection Impairments, Health Care Agencies (HCAs) must report any known interruption to, flaw, or defect in any: 1. sprinkler or other fire extinguishing systems; or 2. fire detection systems or intrusion systems within 48 hours.

On March 18, 2013 HCPP sent out a Notice of Change to all the HCAs instructing them to report Fire Impairment Notices directly to HCPP. In the past, impairment notices were sent to Marsh Canada but as of April 1, 2013 HCPP requires all HCAs to send their Fire Impairment Notices directly to us. The reporting form for these notices has been updated into a fillable PDF form located at www.hcpp.org under the Forms tab.

We thank you for your commitment to this mandatory process. HCAs should ensure they have the most current version of PDF software for the Fire Impairment Notice to work effectively which may require working with your IT department. Please contact us if you have any questions regarding this change.➤

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

It should be clearly understood that this document and the information contained within is not legal advice and is provided for guidance from a risk management perspective only. It is not intended as a comprehensive or exhaustive review of the law and readers are advised to seek independent legal advice where appropriate.

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