HIROC

THE HIROC CONNECTION

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Hospital Found Liable for "Bad Faith" Revocation of Privileges - Cautionary Tale

In the recent case of Rosenhek v. Windsor Regional Hospital, released January 18, 2010, the Court of Appeal upheld a trial decision awarding Dr. Rosenhek over $3,000,000 in damages, stemming from what the Court described as a "bad faith" revocation of Dr. Rosenhek's privileges. The decision is important from a hospital perspective, as it illustrates circumstances in which a hospital could be found liable for civil damages stemming from the revocation of a physician's privileges. This article will provide a brief history of the case, an overview of the Court's finding of bad faith, and discuss where problems arose in the context of the hospital's management.

Background

Dr. Rosenhek was first granted privileges at Windsor Regional Hospital in July 1984, as a specialist in cardiology. When he arrived at the hospital, there were plans to develop a critical care unit. This unit was to be staffed by a number of specialists, who would be responsible for each other's patients. The plan was opposed by many of the specialists with privileges at the hospital already and ultimately did not go ahead. Unfortunately, the rift over the plan left personal divisions among the specialists. Dr. Rosenhek was seen by some as arrogant and overly demanding, and found himself excluded from the specialists' on-call coverage group. Despite Dr. Rosenhek's complaints that the resulting stress and workload was affecting his health, hospital management declined to intervene in the coverage problem, viewing it as a private matter among the specialists.

The Board renewed Dr. Rosenhek's privileges for three months in January 1989. However, in March, the Medical Advisory Committee (MAC) recommended the immediate revocation of Dr. Rosenhek's privileges. Two days later, the Board adopted this recommendation and revoked Dr. Rosenhek's privileges, effective immediately. Without prior notice, Dr. Rosenhek was handed a letter advising him of the revocation and escorted out of the building.

Dr. Rosenhek successfully appealed the Board's revocation decision on the basis that he was not afforded adequate notice. A new hearing was held before the Hospital Appeal Board, resulting in the reinstatement of Dr. Rosenhek's privileges. In 1996, seven years following the revocation of his privileges, the Appeal Board found the Hospital's case came down to the allegation that Dr. Rosenhek simply "did not fit in". Dr. Rosenhek then sued the hospital for damages based on his alleged loss of income during the ten year period that he was denied privileges at the Hospital.

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Finding of bad faith made against the Board

The Court of Appeal identified three significant areas informing their decision that the Hospital Board had acted in bad faith when they revoked Dr. Rosenhek's privileges. First, the Court found that the Board had shown no basis upon which it could revoke Dr. Rosenhek's privileges. The overwhelming weight of the evidence indicated that the problems were minor. The hospital's only evidence came from the Chief of the affected department, whom the Court noted was at the forefront of those denying Dr. Rosenhek access to the on-call coverage group. In contrast, Dr. Rosenhek had numerous witnesses testify in his favour. The Court ultimately held that the hospital's case rested on the mere allegation that Dr. Rosenhek "just did not fit in" with the other specialists at the hospital.

Second, the Court found the timing and manner of the Board's decision suggested it was made in bad faith. They held there was no evidence showing that circumstances had changed between January, when the Board renewed Dr. Rosenhek's privileges, and March, when his privileges were revoked. Therefore, the decision appeared arbitrary and unwarranted, especially because there had been no issues regarding Dr. Rosenhek's competence as a physician. In addition, the Court took issue with the hospital's conduct when they revoked Dr. Rosenhek's privileges. They found it difficult to understand, absent bad faith, why Dr. Rosenhek's privileges were terminated immediately and without notice, given his acknowledged competence and the absence of any patient safety issues.

The third and most significant factor, according to the Court, was the evidence of an improper motive in revoking Dr. Rosenhek's privileges. The Court found the hospital's predominant purpose in revoking Dr. Rosenhek's privileges was to resolve the on-call coverage dispute among the specialists. This, it held, was an ulterior purpose not made for the public good and therefore constituted bad faith.

Where things went wrong

Problems first arose when the hospital declined to take an active role in resolving the on-call coverage dispute. The Appeal Board found in general, hospitals have an obligation to ensure appropriate coverage arrangements are in place for physicians. Furthermore, the fact that the Chief of the affected department was at the forefront of those who denied Dr. Rosenhek access to the coverage group was not looked upon kindly by the Court. The Court's focus became the hospital's "ulterior motive" to resolve a coverage dispute, rather than what may actually have been a collegiality issue.

Additional problems arose from the manner in which the Hospital went about revoking Dr. Rosenhek's privileges. The Appeal Board found the hospital did not provide adequate notice to Dr. Rosenhek in accordance with procedural fairness and the rules of natural justice. They took into account the fact that Dr. Rosenhek was never given notice of the MAC meeting in relation to his privileges, nor was he given notice of the MAC's recommendation to revoke his privileges. Furthermore, he was not given the opportunity for a hearing before the Hospital Board, and was therefore not able to respond to the MAC's recommendation. The Appeal Board also concluded that there was insufficient evidence to support the need for an urgent unilateral revocation of privileges.

Because of these departures from the rules of natural justice, the hospital ended up tangled in years of litigation, some of which could likely have been avoided. In addition, the arbitrary manner in which the Hospital summarily revoked Dr. Rosenhek's privileges informed the Court of Appeal's decision that the revocation was made in bad faith.

Conclusion

In the end, the Court of Appeal held that:

The Board, in bad faith, exercised its decision-making function for an ulterior purpose and not for the public good, in circumstances where it had to know that its conduct would likely injure the plaintiff. We are satisfied that the tort of misfeasance in a public office was made out.

This decision is a cautionary lesson for hospital Boards and administrators. Although members of the medical staff are considered independent practitioners, this does not relieve the hospital from playing a role in monitoring and resolving conflict. Moreover, a solution that resolves conflict, but fails to afford natural justice, may expose the hospital to a claim for civil damages.

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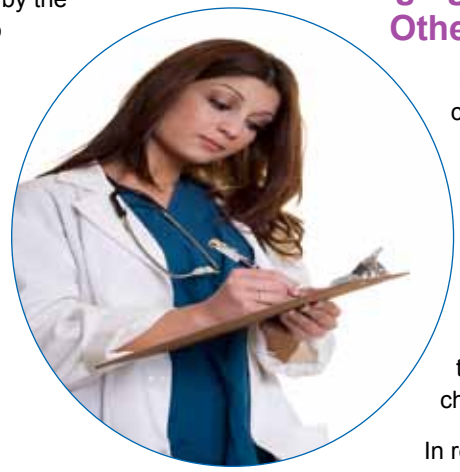
Patient Safety

Improving Collaboration and Maximizing Provider Competencies in Birth Units

A recently completed Interprofessional Relations Project, spearheaded by the Association of Ontario Midwives (AOM), has provided maternity care providers at eight hospitals with the tools to strengthen interprofessional collaboration and facilitate health care providers working to their full level of competency.



The project, funded by a grant from HealthForceOntario, made an interprofessional team of experts available to facilitate discussions and action plans at education rounds and full-day retreats for all providers involved in maternal and newborn care. Participants included midwives, nurses, obstetricians, pediatricians, family doctors and anesthesiologist.

The purpose of the project was to provide a forum that opened communication and fostered mutual interprofessional understanding among birth unit colleagues with the goal of improving participants' understanding of each other's expertise, assisting with midwives integration into the hospitals, supporting patient safety and facilitating health care providers' ability to work to their full level of competency.

The Eion Stalker Inquest

The AOM's project was modeled after a program conducted at Guelph General Hospital, which was implemented following the 2001 Stalker Inquest. The inquest highlighted miscommunication and mistrust among maternity care providers at Guelph General as primary factors that led to the tragic death of baby Eion Stalker. The program that was developed in response to the Coroner's findings aimed at reducing risk within birth units by improving communication, creating documentation and protocols between midwives and other health care providers, and by facilitating increased integration of midwifery into Ontario hospitals.

Bringing the Recommendations to Other Hospitals

Based on the success of the program conducted with providers at Guelph General, the AOM contracted with eight hospitals in Ontario, each of which created an interprofessional birth unit working group. The working groups, whose focus was on ensuring interprofessional participation in the project, began by customizing and distributing a survey to all members of the birth unit to determine hospital-specific challenges to interprofessional collaboration.

In response to the survey results, the project's second phase had health care providers from the hospital birth units participate in educational rounds. The rounds were hosted by one of the project's consultants, Dr. Alan Stewart, who, as the former Chief of Staff at Guelph General Hospital, oversaw the process at Guelph General. Drawing on that experience, Dr. Stewart highlighted reasons why integrating midwives fully into hospital birth units would provide benefits to hospitals, patients, and care providers. Altogether, nearly 190 professionals attended the rounds at the eight sites.

Customized Full Day Birth Unit Retreats Provide Opportunities to Resolve Barriers

Following the educational rounds, each of the eight teams attended an all-day birth unit retreat, drawing over 180 participants in total. The birth unit retreats were customized to each hospital and were led by a professional facilitator, Linda Tarrant, along with Katrina Kilroy, Registered Midwife and the President of the Association of Ontario Midwives, Kim Moore, Nurse Manager in a hospital birth unit and Dr. Alan Stewart. At one hospital retreat, HIROC and CMPA attended to help participants better understand the liability coverage of providers on the birth unit. During the retreat, participants discussed conflict resolution, key issues the unit needed

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to address and what each team member thought an ideal birth unit would look like within their own hospital.

Participants then identified barriers to interprofessional collaboration within their unit and chose three key issues to address. Issues identified by the eight hospitals included:

- the need to improve communitcation;
- enable all providers to work to their full competencies;
- provide opportunities to observe and understand midwives' work;
- improve transer of care protocols and;
- clarify misconceptions about liability issues.

The third step saw participants developing individualized recommendations to address these needs. Recommendations included creating a working group to develop transfer of care protocols, developing a debriefing process to discuss cases, defining normal birth at the hospital, developing a protocol outlining the roles of midwives and nurses to facilitate midwives maintaining care of their clients when an epidural is administered, establishing regular educational rounds, reviewing triage guidelines and developing guidelines to improve communication.

Evaluation of the Project

Following each birth unit retreat, a qualitative evaluation was conducted to assess its effectiveness. An additional and final evaluation was conducted at the end of the project that evaluated the effectiveness of the entire process and to see whether or not the birth units were moving forward on implementing the agreed upon changes. An overwhelming 86% of respondents in the final evaluation stated that the primary challenges to interprofessional collaboration in the birth unit were addressed during the birth unit retreat and 80% of respondents felt that these challenges were going to be resolved as a result of the decisions made at the retreat.

Birth Unit Collaboration: Moving Forward

As hospital birth units across Ontario continue to engage one another in dialogue and implement the tools they developed at the retreat, we would expect to see strengthened interprofessional collaboration in each of the eight sites. Even for hospitals that did not participate in this project, there are opportunties to increase interprofessional understanding among maternity care providers. The AOM is offering an educational round on homebirth entitled, "Homebirth: Facts, Biases and Liability." The purpose of this presentation is to give health care providers a better understanding of homebirth as an option for Ontario women. In addition, the AOM is able to provide information on this project to hospitals interested in supporting facilitated meetings or retreats in their birth units.

Alisa Simon
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Association of Ontario Midwives

HIROC's 23rd Annual General Meeting and 8th Annual Risk Management Conference

Registration for this event, scheduled for April 26th, 2010, is now available online. As registration is filling up quickly, register early to avoid disappointment.

Conference registration is limited to 200 individuals, so if you are unable to attend, please contact Tracy Robinson at **trobinson@hiroc.com.** Please advise as soon as possible, so that others on a waiting list may attend.

We look forward to seeing you there!

Please register for each event you plan to attend, through the following link: **http://www.hiroc.com/agm/**

Surge Protection: Spend a Little Now or Pay a Lot Later!

Picture a snowy January late at night. The weather is at its worst. In between bouts of heavy wet snow, the power suddenly goes out in the hospital. At once, the backup power generator goes into action, keeping essential patient care equipment functioning. When the rest of the hospital power is finally restored, several departments report difficulty restarting a few pieces of sensitive biomedical equipment.

An investigation later revealed that a large power surge occurred when lightning struck either the hospital or the land surrounding it several times. A power surge is an increase in voltage above what is considered normal in the electrical flow. Typically, standard household voltage is 120 volts in Canada. If the voltage rises above 120 volts, equipment may be damaged if it is not connected to a surge protector. In the hospital's case, the excessive electrical pressure that was generated by the lightning overpowered the electrical infrastructure and several pieces of expensive equipment were damaged. A surge protector or uninterruptible power supply (UPS) was not used.

When the hospital later reverted from backup to normal power, the many pieces of equipment in the hospital restarted and began drawing power all at once, which created a brief demand for power. This further destabilized the electrical flow in the hospital.

Other factors that may contribute to problems with electronic equipment, power surges or even power loss in your organization include:

Electrical grounding

Surge protectors and UPS devices cannot perform effectively if the electrical outlets are not properly grounded.Since grounding is ultimately responsible for diverting the power that would otherwise go into your electrical device, organizations should ensure the ground wiring has been installed correctly. The cost of an electrician's one-time evaluation will undoubtedly save money later on. Remember to keep the report and any documentation they provide.

Operating temperature

High temperature can cause permanent damage to an electrical device's internal components. In the case of a UPS, overheating it may leave connected items vulnerable. Ensure all vents and fan outlets on any piece of electronic equipment remains unblocked and able to draw fresh air into the device at all times to keep it cool.

Organizations should verify that UPS devices located in offices are not blocked with other equipment, boxes or other items that might prevent heat from escaping. An inspection schedule may prove useful in identifying areas needing improvement.

Overloaded circuits

If an excessive amount of electrical items are connected to a single circuit, the electrical supply can become overwhelmed and fail. In the worst cases, excessive demands for energy can result in a power failure or a fire. Never exceed the safe operating range of a circuit.

Your electric company may be able to put you in touch with qualified experts such as engineers or electricians who can conduct measurements to determine electrical load. They will advise what can be done to ensure safety.

When selecting a UPS to protect an electronic device, consider the following:

Power

A UPS that does not have sufficient power cannot prevent data loss resulting from a power failure. The UPS you select should be rated to carry the power load on the devices you intend to protect.

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Available outlets

UPS devices supply electricity to electronic devices when the power fails. Several models also provide outlets with surge protection to protect against inadvertent increases in power. Don't forget to check the number of surge protection devices you will need in addition to the number of required battery backup outlets.

Level of protection

When a powerful spike occurs, the actual surge protector or UPS can be damaged to the point of no longer functioning. This will leave the equipment connected to it unprotected and subject to another spike. Always ensure the model you use has a mechanism to alert you when it has been compromised. Several models do this with warning lights while others simply do not provide power to the equipment connected to it.

Telecommunication lines

Computers connected to UPS devices may remain exposed to a power surge if the link between your telecommunication provider's data line and your computer system is not protected with a UPS also. If a power surge occurs, the current may flow through the data line and damage any electronic devices connected to it.

Low Battery Alert

This alert will let users know that the batteries are failing, which leaves time for their replacement. The worst time to discover this would be during a power outage when the battery fails during the system shutdown process.

Register the warranty

Prior to purchase, review the manufacturer's warranty and any applicable limitations including those placed on certain medical devices. Always register a surge protector or UPS the day you install it or coverage for damage related to a power variance may not be granted.

Unfortunately, surge protectors will not protect equipment in all instances. Systems protected with surge protection devices may still sustain damage, however, this is less likely to happen if one is installed properly. So what makes a good surge protection device and how much protection does it really provide?

Insurance considerations

Regardless of your organization's size, you should save insurance policies and any additional documentation provided by your insurer that addresses special coverage of computers and associated electronic devices. Review your organization's property and casualty insurance policies annually to determine if additional coverage is necessary based on new acquisitions.

HIROC suggests that your organization develop a formal process to record all model and serial numbers, as well as the purchase price of the equipment. Photographs should be taken for the more expensive and specialized equipment. Finally, maintaining these items in a secure location can help your organization recover much more quickly should a loss occur.

Don't forget about surge protection to your phone line, if you have a modem connected!

Surges attack over four electrical pathways: hot, neutral, ground, and via phone lines. Protecting only one can leave you vulnerable to damage. On a single-fuse system, if a surge takes out the fuse, all three sources of protection are nullified. In a three-line surge protector with three fuses, if a spike or surge takes out the first fuse, or catches only the "leading edge" of a surge, the second circuit takes over to block or reroute the surge with the third circuit absorbing the remainder.

The effectiveness of three-line protectors also depends on the construction of the device. This includes the speed with which it works and the voltages it can handle, block, or absorb. Price alone is not a reliable indicator, and not everyone needs the same type of device.

There are far more sophisticated systems for surge protection than those mentioned here. These include systems providing emergency power backup, which can cost many hundreds of thousands of dollars. The type of protection your equipment requires must be examined on a case-by-case basis.

Getting Selection Help

To determine your needs, see a qualified expert. Your electric company can conduct measurements to determine electrical activity. Have a consulting electrical engineer or electrician check your electrical environment to determine power loads and the necessary level of protection. afterward, the consultant can advise you of appropriate surge protection requirements.

Alex Szabo
Healthcare Risk Management Specialist
HIROC

New Subscribers of HIROC

We are pleased to welcome the following new subscribers that have joined HIROC since the December 2009 publication of ***The HIROC Connection***.

ONTARIO

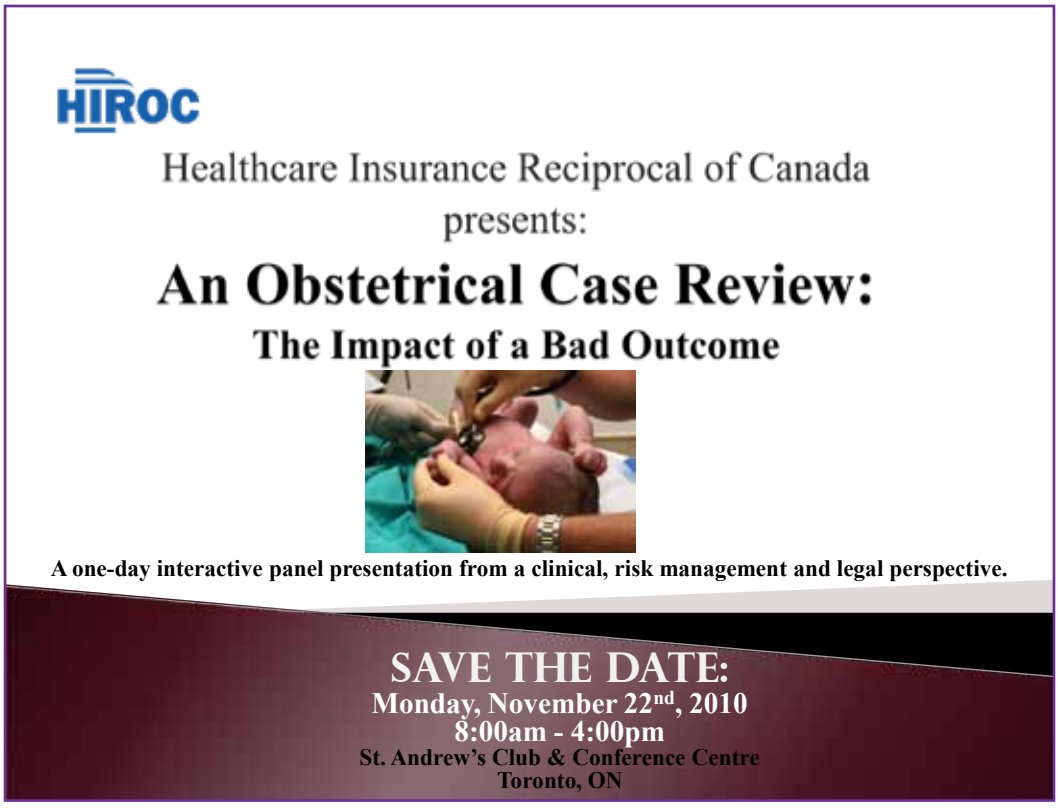
The Canadian Home Care Association (CHCA) is a national membership association that ensures availability of accessible home care and support to people enabling them to stay in their homes with a sense of safety and well being. The CHCA is the main voice of home care and consists of individuals and organizations committed to its continuous support. Ms. Nadine Henningsen is the Executive Director for this Association located in Mississauga, Ontario
.

Ross Memorial Hospital officially opened its doors in 1902. Located in Lindsay, Ontario, this community-based hospital has continued to provide an extensive range of quality patient care services and programs to more than 80,000 residents of the Haliburton, Kawartha & Pine Ridge region. Major expansion of the hospital has included a larger emergency department and new a Complex Continuing Care wing with Rehabilitation and Palliative Care. Mr. Brian Payne is the President and CEO, and Mr. Leo P.G. Boyle is the Vice President, Resources.

Woodstock General Hospital provides primary and specialized healthcare to approximately 54,000 individuals in the catchment area of Oxford County, Ontario. This community hospital is fully accredited under the national standards of Accreditation Canada and has served Woodstock and District since 1895. Ms. Natasa Veljovic is the President and CEO, and Ms. June Spruce is Director of Patient Care, Continuing Care/Risk Management.

NEW BRUNSWICK

The New Brunswick College of Dental Hygienists is a regulatory body whose purpose is to regulate the dental hygiene profession by developing and improving standards for the best interest and protection of the public. Regulations include and pertain to licensing requirements, continued competency, code of ethics and promotion of education. Approximately 388 members are licensed in the Province. Ms. Diane Theriault is the Interim Registrar of the NBCDH located in Moncton, New Brunswick.



Canadian Patient Safety Week at the Peterborough Regional Health Centre: "Ask Listen Talk"

Canadian Patient Safety Week is a nationally designated annual event led by the Canadian Patient Safety Institute to increase the awareness of patient safety issues in Canada by sharing best practices and expanding awareness of patient safety issues to patients, families, health care workers, physicians and the public.

The enthusiasm and participation for patient safety at the Peterborough Regional Health Centre (PRHC) located in Peterborough ON, was outstandingly evident during Canadian Patient Safety Week in November 2009.

The PRHC is a state of the art regional hospital with a proud history extending back over a century. It services a population of 300,000 people in four counties. Our hospital is the region's largest employer with more than 2,200 employees, approximately 350 physicians with privileges, and boasts more than 600 volunteers. Enhancing quality and patient safety is a strategic priority at PRHC.

During the week in November, we strategically connected our patient safety activities and communications to key elements of a safe patient culture.

Demonstrating support from Leadership

Our President and CEO Ken Tremblay introduced the event with the message that Canadian Patient Safety Week was an opportunity for us to focus on the obligations and opportunities we face as healthcare providers every day. The message focused on the fact that patient safety is essential from the decisions made by the Board of Directors, to our diligence in hand hygiene; to each and every conversation we have with our patients.... "it's the cornerstone of the work we do". The message from the Mr. Tremblay encouraged staff, physicians and volunteers to review the results of our Patient Safety Culture Survey and share their thoughts on proposals to further a culture of patient safety.

His message introduced the Patient Safety Leadership Walkabouts that would be piloted during Canadian Patient Safety Week. The walkabouts are a recent best practice for hospitals in North America intended to improve quality and patient safety by increasing awareness and communication of patient safety issues among senior leaders and staff, for identifying and acting on patient safety issues and educating senior leaders and staff about important patient safety concepts.

Mr. Tremblay also informed staff that Dr. Michael Baker, Executive Lead for Patient Safety at MOHLTC, attended the Board of Director's meeting and expressed his accolades for PRHC's patient safety initiatives, specifically highlighting that PRHC is a Provincial leader in hand hygiene and surgical checklist implementation. All staff and physicians were congratulated for their work.

Sharing compelling stories about harm

A family member of a patient told his story about his father's experience with a hospital-acquired infection to the PRHC Board Quality of Care Committee and to our Leadership Forum. This experience came to the attention of the Patient Relations Consultant through a telephone call. After listening to the son's story it was realized that this story gave a real human dimension to an experience and gave us the opportunity to learn. We were grateful to the son for taking the time to come to PRHC to share his father's compelling story.

We also shared the Josie King Story video to several staff members and to our leaders during Patient Safety Week. The story emphasized the importance of communication amongst healthcare team members and communication to the families of patients. A debriefing and discussion on the importance of communicating with patients and families to prevent harm, was led by one of our experienced Emergency nurses who is known as an expert listener and communicator. The story has since been shared with our Leadership Team and offered throughout the hospital to employees.

PRHC's Calendar of Events - Promoting learning through hands-on, interactive games

Donning and Doffing Competition

Donning and doffing personal protective equipment is an important action we take every day to protect patients, families and staff from infectious diseases. An Infection Control Practitioner was on hand to ensure that the speed of donning and doffing was not to reduce the quality of the practice. The competition was held in our main foyer which enabled staff, physicians and even visitors to become active participants in the activity or to be observers in the learning. There were lots of freebies for hand hygiene handed out during this activity and throughout the week.

Falls Risk Room

A falls risk room was set-up with several environmental risks for falls. PRHC has a Preventing Harm from Falls Program to help assess these risks and put strategies in place to reduce the likelihood and harm from a fall. Participants in this challenge were asked to identify the risks for falls and submit their answers. Staff were reminded to assess for mobility, identify and develop a plan to reduce risk, and encourage patients to "call before they fall"!

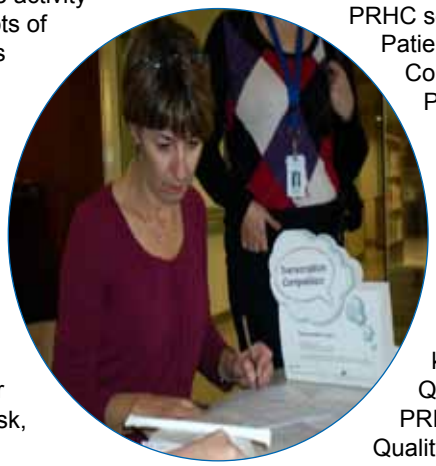
Teddy Bear Picnic – Identifying Patients Correctly

A table was setup in our main foyer for a Teddy Bear Picnic. Nine teddy bears were given arm bands that displayed their name, date of birth and hospital number. At least two identifiers were required to be used to identify the Teddy Bear with the place card at the picnic table. Participants had to be careful not to confuse teddies with sound alike names i.e. Frizzy and Fuzzy Bear. This exercise proved to be a lot of fun and sparked interest especially from the visitors entering our hospital. It gave us the opportunity to explain to them the importance our staff place on the proper identification of our patients.

Medication Transcription Competition

Careful transcription of medication information is an important step to ensuring that patients are on the right type and amount of medication. In this exercise, participants were reminded to use only designated "safe" abbreviations and to know where to find a list of PRHC's error-prone abbreviations. Topnotch ward clerks and the medication safety consultant were available to monitor and 'Yes' add time to the competitor's score if any mistakes were made.

Linking to Accreditation 2010



Accreditation was six months away for PRHC so we took this opportunity during Patient Safety Week, to navigate Communication and a Culture of Patient Safety as our focus for the month of November. We posted 50 "Ask Talk Listen" clouds with key "Did You Know" messages about accreditation required organizational practices (ROP) in public areas around the hospital. We held a quiz competition testing staff's knowledge about these practices. Questions included identifying the PRHC strategic priority of "High Quality Patient Care, A Great Place to Work and a Strong Regional Centre"; identifying that Patient Safety is the responsibility of all staff, physicians, leaders, volunteers, patients and families; identifying key activities for patient safety and proper identification using two identifiers.

Winners of all the week's competitions were awarded with "Ask Talk Listen" prizes from the Canadian Patient Safety Institute and donations from staff and local community sponsors.

Patient Safety is at the forefront of everything we do at PRHC. There was a lot of fun and learning during Canadian Patient Safety Week 2009 and we look forward to next year's events.

Darlene Mack
Privacy Officer and Risk Management Consultant
Peterborough Regional Health Centre

FEATURE

Ask a Lawyer

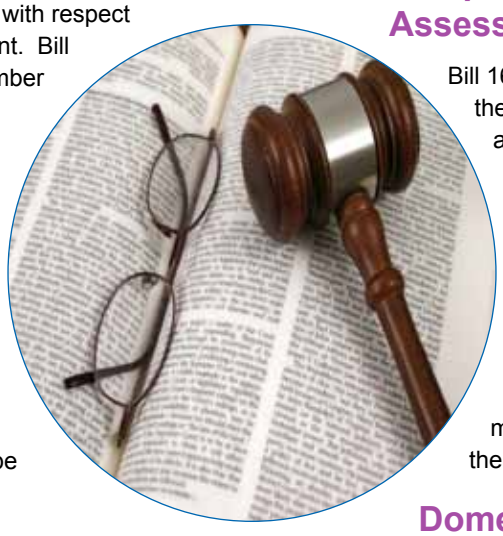
Q: I have heard a lot recently about Bill 168. What is Bill 168?

A: Bill 168 amends the Occupational Health and Safety Act (OHSA) by imposing new obligations on employers with respect to workplace violence and harassment. Bill 168 received Royal Assent on December 15, 2009, and will come into force on June 15, 2010.

Definition

Bill 168 contains the following definitions:

Workplace harassment means "engaging in a course of vexatious comment or conduct against a worker in a workplace that is known or ought reasonably to be known to be unwelcome."



Workplace violence means:

a) the exercise of physical force by a person against a worker, in a workplace, that causes or could cause physical injury to the worker;
b) an attempt to exercise physical force against a worker, in a workplace, that could cause physical injury to the worker;
c) a statement or behavior that is reasonable for a worker to interpret as a threat to exercise physical force against the worker, in a workplace, that could cause physical injury to the worker.

Policies and Programs

Bill 168 requires employers to prepare workplace violence and harassment policies. Employers must also develop programs to implement these policies. These programs must include measures and procedures to:

• control the risks identified in the workplace violence assessment;
• summon immediate assistance when workplace violence occurs or is likely to occur;
• report incidents or threats of workplace violence to the employer or supervisor;
• establish how the employer investigates and deals with incidents or complaints of workplace violence.

New Workplace Violence Assessments

Bill 168 requires employers to assess the risk of workplace violence. This assessment shall take into account both circumstances common to similar workplaces and circumstances specific to the employer's workplace. A copy of the assessment must be provided to the Joint Health and Safety Committee or the health and safety representative. If there is no such committee or representative, workers must be advised directly of the results of the assessment.

Domestic Violence

Under Bill 168, employers are required to "take every precaution reasonable in the circumstances" to protect workers from domestic violence that would or likely expose a worker to physical injury in the workplace. However, this obligation arises only if the employer is aware or "ought reasonably to be aware" of the domestic violence. Bill 168 does not define domestic violence.

Disclosures of persons with a violent history

Bill 168 obligates an employer to provide information, including any personal information, to workers about a person with "a history of violent behavior" if (a) the worker can be expected to encounter that person in the course of his or her work and (b) the risk of workplace violence is likely to expose the worker to physical injury. Bill 168 does not define history of violent behavior and provides no guidance as to what information must be provided other than stipulating that employers must not disclose "more information than is reasonably necessary to protect the worker from physical injury".

Refusal of work

Under OHSA a worker may refuse work that he or she believes is unsafe. Bill 168 further provides that a worker may refuse work where he or she believes that workplace violence is likely to endanger himself or herself. The procedure through which a worker refuses work is set out in OHSA.

In short, under Bill 168, employers have increased responsibilites to protect workers from workplace violence and harassment.

Gordon Slemko
General Counsel
HIROC

This column is intended to convey brief and general information and does not constitute legal advice. Readers are encouraged to speak to legal counsel to understand how the general issues discussed in this column may apply to their particular circumstances.

Subscribers are invited to submit questions **of a general legal nature** to our resident general counsel Gordon Slemko at **gslemko@hiroc.com**. Gord will select from the queries submitted and will provide his corresponding response.

Healthcare Risk Management Network News

Risk Management Network Adopts New Name

OHRMN (Ontario Healthcare Risk Management Network – becomes CHRMN (Canadian Healthcare Risk Management Network

The Ontario Healthcare Risk Management Network (OHRMN) was founded in 2001 as a forum for healthcare professionals to discuss current issues in risk management, patient safety and quality. Over the years, OHRMN's membership has expanded and now includes organizations across Canada. In 2008, in order to reflect the network's growing Canadian membership, it was decided to look for a new name and the Canadian Healthcare Risk Management Network (CHRMN) was born.

Through its membership, the CHRMN facilitates knowledge sharing, collaboration, learning activities and provides direct access to information related to standards, practices, guidelines, policies and procedures.

The CHRMN is pleased to announce its new Executive for 2010:

Chair	Shirley Atkinson	Manager, Quality and Risk Management, Rouge Valley Health
System Vice-Chair	Corinne Berinstein	Senior Audit Manager, Ministry of Finance, Province of Ontario
Past-Chair	Pat Fryer	President & Senior Consultant, Patricia Fryer and Associates Inc.
Secretary Treasurer	Arlene Kraft	Manager, Healthcare Risk Management, HIROC
Education Chair	Kathryn Callfas	Healthcare Risk Management Services Consultant, HIROC
Nomination Chair	Anita Harris	Vice President, Clinical Affairs, Hotel-Dieu Grace Hospital
Membership Chair	Joanna Keown	Healthcare Risk Management Specialist, HIROC
Committee Members	Catharine Butler Jackie Smylie	National Director, Quality and Risk Management, VON Canada Manager, Quality and Risk Management Services, Brockville General Hospital

For information about joining the CHRMN, please contact Joanna Keown, Membership Chair at **jkeown@hiroc.com**

Making Sure You Are Adequately Protected

We have all read about high court awards and the increase in the number of class action suits in the newspaper lately. What does this really mean for your health care organization?

The largest court award in Canada to date for catastrophic neurological impairment is $18.5 million so do you really need limits of more than $20 million? If your organization provides obstetrical services or treats infants, the answer is "yes" as catastrophic neurological impairment forms the basis of most infant claims. If you report a claim, your current limit is the maximum amount that will be paid when the claim is eventually settled. Claims inflation is increasing at 8% per year and the average infant claim takes six years to settle. With annual compounding, it is expected that in six years the largest court awards will be over $25 million. While it is true that most settlement payments involve physician and the hospital, it is also true that there are cases where hospitals are found responsible for the full cost of the settlement. In particular, infant claims generally involve allegations surrounding the failure of the nurse to properly monitor the patient, and this certainly exposes the hospital to significant risk. While many claims do settle within two or three years, some infant claims can take eight or nine years to settle, which translates into even higher court awards.

Another reason to consider higher limits is the proliferation of class action suits in Canada. Total court awards for this type of litigation are large due to the number of claimants involved. If you feel your organization is at risk for lawsuits of this nature, it would be wise to explore additional limits.

We want to make sure all of our subscribers are adequately protected. This is why HIROC is pleased to offer limits of up to $30 million any one occurrence as of January 1, 2010. We have been able to negotiate favourable rates with our reinsurers so the costs are not prohibitive. If you are interested in a quotation, please send an e-mail to **quoatations@hiroc.com** or contact Heather Galli, Manager, Insurance Operations to obtain a costing or to discuss this matter in further detail.

HIROC presents its first in a series of Videoconferences for 2010

Consent and Capacity: Discussion of Current Topics and Trends

Thursday, April 8, 2010 10:00 - 11:00 a.m. (EST)

Presenter: Katharine Bryick, Partner, Borden Ladner Gervais LLP

Please register for this event through the following link:
http://www.hiroc.com/ras_education_and_conferences.asp

Mark your calendars for upcoming HIROC Videoconferences

Health Emergency Planning

Thursday, May 13, 2010 10:00 - 11:00 a.m. (EST)

Presenter: Tiffany Jay, (Acting) Director Emergency Management Branch, Public Health Divison, Minister of Health and Long Term Care

Property Losses

Thursday, June 10, 2010 10:00 - 11:00 a.m. (EST)

Presenter: Gregory Bourne, Account Engineer, FM Global

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