

Report of the Healthy Workplace Initiative

2007



...In Healthcare Workplaces in Newfoundland and Labrador



"Healthcare providers and administrators are the backbone of our healthcare system. They are trained to promote good health, to care for and comfort the sick, to expand what we know about health and healthcare and to improve the effectiveness of the way the healthcare system functions... If one of the goals of the healthcare system is to promote health and prevent illness and injury, it may be logical to start with those who work in the system." (CIHI, 2000)¹

Preamble

Message from the Project Leader

It has been an honour to serve as Leader of the Healthy Workplace Initiative: *Creating a Culture of Safety* for the past eighteen months. This role has allowed me to interact with healthcare workers throughout the beautiful province of Newfoundland and Labrador and to broaden my perspective on workplace well being in the healthcare environment.

This final report arising from the Healthy Workplace Initiative does not provide all the answers to the long-standing problem of accidents and injuries in the healthcare work environment, but it can serve as the impetus for a new approach leading to meaningful change if there is a sincere desire to end the physical and psychological harm that has befallen healthcare workers and the resulting fiscal damage to the healthcare system.

Many amazing people have contributed to the outcomes of this initiative - dedicated professionals who attended focus group discussions and spoke passionately about the work they love, steering committee members who gave freely of their time, tireless individuals who devoted countless hours to working group activities, committee members who provided insights into daily challenges and so many others who helped out in countless ways. Their dedication serves as a testament to the commitment they bring to their work as supporters, administrators and providers of healthcare.

It is that same dedication that has contributed to the ills befalling health and safety in the healthcare workplace. Healthcare workers have earned a reputation for putting the needs of others ahead of their own, while managers and decision makers walk a psychological and fiscal tightrope in dealing with competing priorities in an increasingly complex system. The physical toll has long been supported by injury statistics. The emotional and psychosocial toll has not yet been fully recognized. This project has looked beyond the statistics that unto themselves paint a picture of a system in need of positive change as described by overburdened managers and weary professionals.

This initiative brought together a diverse group of stakeholders who demonstrated the value in a collaborative approach to confronting a problem that has taken a serious toll on the health system for far too long. It is my hope that this collaborative spirit will live on in a renewed dedication to creating safe and healthy healthcare workplaces.

This is an exciting time to be involved in the healthcare system in Newfoundland and Labrador. It is a time that embraces innovation and ingenuity. It is a time when “health” has been elevated to priority status in a system that has traditionally focused on “care”. It is a time of increased demand for accountability to ensure that vital services are delivered in the most efficient and effective means possible.

At the outset there was a very specific set of objectives and expected outcomes for this initiative. As time went on, the project took on a life of its own in a system that cried out for collaboration and information sharing, resulting in the emergence of several new avenues of communication that have demonstrated their value and will hopefully be sustained into the future. Never before had there been a communications tool dedicated exclusively to occupational health and safety in the NL healthcare environment and now there are several in the form of a newsletter, *Safety Shift*, and a website, www.safetyculture.ca, complete with discussion forums to facilitate information sharing between health and safety professionals, committees, ergonomists and healthcare workers. A provincial conference concluded the project, bringing together delegates from all regions for an event that provided the first such opportunity for knowledge sharing and networking.

The project has also served as a central resource in coordinating the activities of provincial working groups that made significant advances through a pooling of resources, expertise, and leading practices, attesting yet again to the value in a collaborative approach to workplace well-being.

The demands of competing for scarce resources in a system that falls under constant public scrutiny can be overwhelming. Healthcare is a montage of industries under one roof with an extensive list of stakeholders made up of clients, residents, family members, visitors, contractors, suppliers, politicians, bureaucrats and last but not least, workers - 18,000 of them - nurses, pharmacists, managers, physicians, porters, cooks, clerks, social workers, painters, audiologists, executives, carpenters, laundry workers, lab technologists, physiotherapists, buyers, educators and more.

The hazards that expose these people to risk of physical and psychological harm can be controlled, but it will take dedication, collaboration and commitment. There is still much to be done to ensure that the health and safety of healthcare workers is given the priority status it deserves. The following pages offer suggestions for building and improving on the efforts that have already begun, while proposing new and innovative ideas designed to create a culture of safety for the good of healthcare workers and those who ultimately benefit the most - the people of Newfoundland and Labrador.

Sincerely,

Bonnie Abbott
Project Leader

“We cannot solve our problems with the same thinking we used when we created them.”
~ Albert Einstein

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Executive Summary

The healthcare system in Newfoundland and Labrador (NL) has addressed the problem of high accident and injury rates through various means over the years, with some degree of success. The Back Injury Prevention Program (BIPP) of the early 1990's introduced mechanical lifting devices and safe work procedures that had a significant impact in preventing soft tissue injuries. Back injuries decreased in the early years, but by the end of the decade, accident rates had made a slow and steady climb, eventually reaching a level that exceeds most other industry sectors.

However, there are still successes in evidence from BIPP, particularly the recognition that it is possible to prevent accidents and injuries in the healthcare work environment. In the pre-BIPP days, very few resources were dedicated to workplace health, whereas the system now employs numerous wellness personnel and allocates millions of dollars annually to the development and administration of safety programs and services. Why then, is healthcare still struggling to reduce injuries, contain costs and achieve legislative compliance?

HWI research sought out the root causes of this enormous problem, identifying potential opportunities for improvement in the physical environment, the psychosocial environment and individual health practices, all of which must be in balance to create healthy healthcare workplaces. A focus on disability management has yielded positive results, but it is now time to make way for a more proactive prevention-oriented culture that models the province's new Wellness Strategy. This calls for transformational change at the centre of which is a need for strategic realignment on an organizational and provincial level that recognizes linkages between quality of work-life and quality of service delivery. A major step in this direction involves greater collaboration among healthcare stakeholders in a sharing of expertise and best practices leading to injury prevention strategies driven by industry needs. This can best be realized through an integrated safety management system / human factors approach.

Given that the healthcare system is in the midst of major restructuring, the time is right for such change but it must be done with care and consideration of the impact of change on the psychosocial health of healthcare workplaces. A number of innovative products, services and technologies are on the horizon, including ceiling-mounted client lifting devices, safety engineered sharps and microfibre mops. History teaches the importance of introducing new processes and products with the support and safeguards that come from a systematic approach involving consultation, evaluation and change management strategies as well as the need to strike a balance between evidence-informed decision making and application of the precautionary principle.

As healthcare prepares for recruitment and retention challenges associated with an aging and shrinking workforce, the need for a culture of safety must be recognized as an integral component of the human resource strategic planning process. A happy, healthy workplace is vital to attracting and maintaining happy, healthy workers who enjoy their work, are kept informed, feel valued, actively participate in decision-making, are afforded opportunity for professional development and perceive their safety and health to be an organizational priority.

Leaders, policy makers, unions and government must recognize the direct link between healthy healthcare workplaces and a sustainable and effective healthcare system. They must be willing to provide the direction, vision, commitment, action and resources necessary to produce the positive actions required to create a culture of safety in healthcare workplaces in Newfoundland and Labrador.



Summary of Recommendations

1. Co-chairpersons of occupational health and safety committees in every workplace should be assigned responsibility to review and disseminate information arising from the Healthy Workplace Initiative - *Creating a Culture of Safety*, including the findings and recommendations in this report as well as the results of the HWI provincial employee satisfaction survey.
2. Persons with responsibility for workplace health and safety at the corporate level within each Regional Health Authority should develop an accountability framework requiring that OH&S committees in each workplace develop an action plan and strategy designed to create or enhance a culture of safety by addressing the findings and recommendations in this report.
3. The prevention function should be separated from the disability management function in terms of resource allocation and/or corporate structure. This can be accomplished by administering disability management programming under the direction of Human Resources Departments while aligning workplace health and safety programming under the administrative structure responsible for other risk management functions.
4. Adequate funding should be provided to ensure that occupational health and safety departments and committees are provided with the resources necessary to produce quality services and programs including paid time for committee members to devote to occupational health and safety activities as required.
5. Standards should be developed that support and encourage ongoing professional development for OH&S personnel with emphasis on the knowledge, experience and academic qualifications necessary to obtain an appropriate professional designation, including:
 - Canadian Certified Professional Ergonomist (CCPE)
 - Canadian Registered Safety Professional (CRSP)
 - Certified Occupational Health Nurse (COHN)
 - Registered Occupational Hygienist (ROH)
6. Research opportunities should be provided for those in the practice of Occupational Health and Safety in order to facilitate evidence-informed decision-making based on sound knowledge, timely information and the precautionary principle.
7. OH&S department structures and hiring practices should be reviewed to ensure that appropriate skill mix is utilized to effectively develop and administer all elements of OH&S programming. This may require realignment of responsibility among various disciplines or amendments to position qualifications.
8. The terms of reference and performance of each OH&S committee should be reviewed by senior administration to determine if appropriate structure and support is provided to allow committees to fulfill their mandated responsibilities as determined by legislation, policy and needs of the workplace.
9. A central resource should be established to provide consultation, advice and technical expertise to OH&S committees and practitioners as a supplement to internal workplace resources.
10. OH&S committees should be engaged in the process of providing ongoing communications regarding workplace health and safety programs and services.

11. Adequate communications processes must be a part of the hazard identification, evaluation and control process.
12. Health Authorities should determine, in conjunction with OH&S committees at each site, the most appropriate and effective means of communicating feedback on control measures being undertaken to resolve identified hazards, particularly those that may be subject to delays in implementation.
13. Corporate communications departments should be engaged to identify innovative and effective means of communicating OH&S policies, programs, committee minutes, hazard alerts and safe work procedures throughout each organization.
14. Hazards in the physical environment must be identified, evaluated and controlled by the most efficient and effective means in all workplaces without delay.
15. Maintenance work order systems should be designed to prioritize work relating to the control of unsafe conditions and track the amount of time it takes to have deficiencies corrected. Monthly reports should be generated for review by senior administrators and OH&S committees.
16. When new facilities are to be constructed or existing buildings to be renovated, there must be consultation utilizing a participatory ergonomics approach involving workers, managers, OH&S professionals and ergonomists. Ergonomics expertise must be consulted at every stage of the process, including schematic design, contract documentation, construction and post-occupancy evaluation.
17. Methods must be identified for assessing and adequately controlling managers' workloads and span of control.
18. Human resources departments should explore alternatives to the traditional performance appraisal process for providing feedback to employees.
19. Employers should develop and track indicators to measure activities impacting the psychosocial work environment in each department or work unit, including:
 - a) Paid and unpaid overtime for workers and managers
 - b) Employee turnover
 - c) Staff meetings (frequency, topics, outcomes, attendance, etc.)
 - d) Number and type of referrals to employee assistance programs
 - e) Total absenteeism of all types
 - f) Grievances (frequency and trend analysis)
 - g) Work refusals
 - h) Concerns referred to the OH&S committee
 - i) Education activities including attendance and impact evaluations
 - j) Disciplinary actions
20. Appropriate support must be provided for employees who work rotating shifts. This includes implementing fatigue management systems and reviewing human resource policies to determine if they are compatible with a complex 24/7-work environment.
21. Health promotion services should be expanded to include relationship-oriented health promotion strategies and quality work-life issues.
22. Employers and labour groups must work together to develop strategies to address the dissatisfaction and disengagement that is prevalent among healthcare workers.
23. Human resources departments should consult with workers, managers, OH&S committees and labour representatives at each workplace to determine priority actions required to create a culture of safety, including:

- a) Conducting impact evaluations to determine if longstanding policies are achieving the intended results.
 - b) Conducting exit interviews with terminating and transferring employees to solicit their input on working conditions and job satisfaction in terms of both the physical and psychosocial environment.
 - c) Developing formal career path with individual employees in disciplines that are subject to high rates of stress, burnout and injury.
 - d) Reviewing innovative retention policies from other provinces and industries.
 - e) Reviewing orientation policies on training in safe work procedures and hazard identification, evaluation and control.
24. Healthcare OH&S practitioners should conduct a thorough evaluation of the various Occupational Health and Safety Management System (OHSMS) options with a goal of adopting a system that can be implemented province-wide.
 25. A process must be implemented to ensure that all occupational health and safety programs are evaluated at various points of implementation and execution in order to determine if they are achieving desired outcomes.
 26. The OH&S Division of the Department of Government Services, in consultation with the healthcare system, should create healthcare regulations focusing on the control of high-risk hazards unique to the healthcare environment.
 27. Healthcare stakeholders must come together to establish a central resource dedicated to assisting the industry to achieve OH&S self-reliance and to provide a collective voice in matters involving legislation and regulatory enforcement.
 28. A mechanism must be developed to provide for ongoing consultation between the sector and the OH&S Division.
 29. Occupational health and safety committees should undertake a review of the key components of the Internal Responsibility System to assess whether or not it is functioning appropriately within their respective workplaces.
 30. The issue of respiratory protection must be revisited immediately by all healthcare organizations to ensure that adequate measures are in place to protect workers from potential exposures to airborne infectious agents. A comprehensive province-wide respiratory protection program should be developed utilizing appropriate expertise in a manner that ensures consistency of application in all workplaces in terms of training, fit-testing, product selection and other vital program elements.
 31. A means of ensuring ongoing, meaningful liaison must be established between joint occupational health and safety committees and infection control committees.
 32. A comprehensive program must be put in place to identify, evaluate and control biological hazards.
 33. The “precautionary principle” should be entrenched in workplace health and safety philosophies throughout the healthcare system to ensure that new work processes, products, services and technologies are researched, evaluated and implemented, without delay, when there is information to suggest that worker health and safety will be improved.
 34. Central knowledge brokerage services should be established to create an OH&S information repository accessible to the entire healthcare system and to facilitate sharing of leading health and safety practices among healthcare organizations.
 35. An initiative should be undertaken immediately to research and develop a systematic approach to introduce ceiling lifting devices, microfibre mops and safety engineered sharps to all healthcare workplaces in the province.
 36. Each Health Authority CEO should commit to signing the Quality Worklife Quality Healthcare Collaborative’s Healthy Workplace Charter.

37. There must be improved linkages between the worker safety function and the risk management/quality function under a human factors philosophy that recognizes the correlation between quality of worklife and quality of service delivery.
38. Ergonomics expertise should be utilized to provide training and information to a broad worker population base including key groups such as facilities maintenance, purchasing departments and biomedical personnel.
39. Managers at all levels must be provided with detailed information regarding their legislated and organizational responsibilities for workplace health and safety.
40. A needs assessment should be conducted in each workplace to determine training requirements in relation to specific hazards, including safe work procedures and the management of hazardous substances.
41. E-learning and other new technologies should be utilized for health and safety training when it is feasible and practical to do so.
42. Managers and workers who routinely use computers in the performance of their work should be provided with instruction in basic keyboarding techniques.
43. Managers must be provided with the tools, education, support and resources necessary to effectively perform their legislated health and safety responsibilities.
44. Managers at all levels in every organization should engage in regular meaningful dialogue about health and safety by informal and formal means, including regular monthly staff meetings and informal conversations.
45. Monthly staff meetings should be mandatory in every department or functional area, with standing agenda items to be determined in consultation with departmental staff using the following as a minimum standard:
 - Health and safety hazards
 - Hazard control communication
 - Staffing, scheduling & workloads
 - Safe work procedures
46. OH&S department personnel and/or OH&S committee members must support managers by attending staff meetings upon invitation and by providing technical advice and consultation as requested.
47. A hazard recognition, evaluation and control program, specific to the community environment, should be established without delay.
48. Current OH&S policies and procedures should be reviewed to determine if they are appropriate for the community environment.
49. Employees who work in remote locations must be provided with adequate means of communicating in emergency situations.
50. Healthcare partners should determine a means of maintaining OH&S communications initiatives such as the newsletter *Safety Shift* and the project website, www.safetyculture.ca.
51. A review should be undertaken of methods by which inter-professional and multi-stakeholder health and safety communication and collaboration can be enhanced throughout healthcare organizations.
52. Provincial working groups should be established to address workplace health and safety issues of common concern throughout the entire system under the coordination of a central resource.
53. The Ergonomics working group should be supported and encouraged to continue developing HWI initiatives and objectives.
54. Workplace conflict resolution mechanisms should be evaluated and new systems established in workplaces where none currently exist.

55. Managers and workers should be educated in conflict management/conflict resolution.
56. Hazard assessments should be conducted to determine where and in what form risks of violence exist within the physical and psychosocial work environment.
57. Violence prevention programming should be developed and implemented that addresses identified risk factors including security services, working alone, self-defence training, conflict resolution mechanisms, non-violent crisis intervention, emergency response, communications and engineering controls.
58. Unions and employers must work together to determine bonafide occupational requirements applicable to security personnel to ensure that they are capable of providing adequate services in dealing with acts of violence in the workplace.
59. The unique needs of the community sector should be assessed in relation to protection from violence, aggression and conflict in recognition of the increased risk created by working alone in an uncontrolled environment.
60. Senior leadership teams must spearhead the changes required to create a culture of safety.
61. Managers must be educated in how to apply the factors necessary to cultivate change successfully.
62. Health Authorities should enact policies ensuring that any money refunded through PRIME rebates will be reinvested directly into activities that have a direct impact on the creation of healthy healthcare workplaces.
63. The Department of Health and Community Services should create a new position for an Ergonomist to be consulted in matters involving capital expenditures, building design, workload measurement, etc.
64. The provincial government should make long-term, multi-year funding investments in the healthcare system to provide for the design and implementation of infrastructure improvements including building upgrades and provisions for engineered injury prevention systems including:
 - a. Increasing the size of patient/resident rooms and bathrooms to provide a safe work environment for individuals engaged in client care.
 - b. Installing ceiling track client lift systems in all newly constructed or renovated facilities.
 - c. Installing or upgrading heating, ventilation and air conditioning systems to provide for a healthy and comfortable thermal environment.
 - d. Replacing manual crank beds with electric beds.
 - e. Replacing sharps instruments with safety engineered devices.
 - f. Introducing microfibre floor cleaning technology.
 - g. Providing adequate storage space.
 - h. Installing guardrails, roof anchors and other forms of engineered fall protection systems identified in working-at-heights hazard assessments.
 - i. Replacing worn, slippery and problem flooring.
 - j. Upgrading or replacing biological safety cabinets.
 - k. Installing communications devices, alarms, barriers, enclosures, dual-swing doors and other forms of engineered violence-prevention systems as identified in violence-prevention hazard assessments.
 - l. Upgrading and improving waste disposal systems.
 - m. Providing human resources information systems with the capacity to track health and safety data, including workload measurement systems that ensure the provision of safe staffing levels.

- n. Developing mechanisms to ensure allocation of sufficient capital and operational funding to ensure that buildings and equipment can be adequately maintained to ensure provision of a safe and healthy work environment.

65. The Health Authorities and their partners as represented on the HWI steering committee should commit to building on the momentum created by this project by establishing and supporting a central resource dedicated to creating a healthcare system that truly embodies a *culture of safety*.



Background

The Health and Community Services system in Newfoundland and Labrador (NL) has undergone many changes in recent years. Restructuring in the mid 1990's resulted in the amalgamation of independent facilities into fourteen administrative boards across service delivery and regional lines.¹ Further streamlining in 2005 saw the creation of four Regional Health Authorities (RHA), each responsible for the entire continuum of health services including acute care, long term care and community health.

Throughout all of this change, one thing that has remained constant is the unacceptably high rate of workplace accidents and injuries. There is no denying that healthcare work is physically and emotionally demanding. Statistics reveal rates of injury and illness that exceed most other industries, not just in NL, but also throughout the entire country. It is these statistics that have long been the drivers behind injury and illness prevention programming and they have come to serve as a measuring stick for success and failure. But research tells us that workplace wellness issues are never quite that simple, particularly in an environment as complex as healthcare. For this reason, *Creating a Culture of Safety* has looked beyond the statistics to present a broader view of this conundrum we call healthcare where 18,000 workers in this province make a living.²

Health Canada's Healthy Workplace Initiative (HWI)

The concept for Healthy Workplace Initiatives (HWI) stemmed from the 2003 First Ministers' Accord on Healthcare Renewal, leading to the Pan-Canadian Health Human Resource Strategy, which seeks to promote healthy working conditions for Canada's healthcare workforce by encouraging more people to enter the healthcare workforce and improving working conditions to retain them³. Health Canada allocated \$3.5 million to support 11 projects across the country, including *Creating a Culture of Safety*.

Healthy Workplace Initiatives are intended to support healthcare organizations in developing or enhancing programs and actions leading to improvements in:

- Work environments
- Health and well-being of healthcare staff
- Job satisfaction and quality of work life.

Creating a Culture of Safety

There is widespread acceptance that healthcare work lends itself to high incident rates as corroborated by statistics from across the entire country. The HWI, *Creating a Culture of Safety*, was initiated in September 2005 to explore issues behind incident rates in NL, which are among the highest in Canada. The project was spearheaded by a creative group of individuals at the former Avalon Healthcare Institutions Board (AHCIB).

For many years, AHCIB had promoted training and education as a key component of health and safety programming, yet there was frustration that a reduction in accidents and injuries had not been realized. The question that prompted the original project was *“Why are frontline workers failing to apply safe practices they were taught in the classroom to their work environments?”*

A basic tenet of occupational health and safety states that problems of this magnitude are rarely ever rooted in single cause. Therefore, it was determined that project activities would look beyond the issue of training in an effort to identify not only the symptoms of unhealthy workplaces but also the deeper cultural barriers to creating healthy healthcare workplaces.

By the time the project was launched, the healthcare system in NL was well into the throes of restructuring. AHCIB had ceased to exist, having become part of Eastern Health, one of four newly formed Regional Health Authorities, the project coordinator had moved to Labrador-Grenfell Health and there was recognition of the value in a collaborative approach involving the health authorities and their partners.

A steering committee was assembled representing each of the health authorities, unions and associated partnering organizations. In total, twenty-one members were appointed and collectively they provided a powerful guiding coalition. Each member was tasked with communicating information about project initiatives to appropriate persons within their respective organizations as well as representing the interest of their organizations at the committee table; thereby providing a vital communications link between the HWI and its stakeholder groups.

Meetings were held in person, by web conference and by teleconference throughout the life of the project. In total, eight meetings were held for the purpose of keeping members informed of activities and engaging their support for initiatives arising from the project.

Organizations represented on the HWI steering committee:

- Labrador-Grenfell Health (administrative sponsor)
- Central Health
- Eastern Health
- Western Health
- NL Health Boards Association
- NL Nurses' Union
- NL Association of Public and Private Employees
- Canadian Union of Public Employees
- Association of Allied Health Professionals
- Workplace Health, Safety and Compensation Commission
- Department of Health and Community Services
- Department of Government Services, Occupational Health & Safety Division



Methodology

In order to gather the information necessary to report on health and safety in the healthcare system, both primary and secondary research was utilized.

Primary research consisted of site visits and focus group discussions held at various locations throughout the province to gather stories, data, anecdotes and real life scenarios about healthcare work (Appendix A). A province-wide employee satisfaction survey was administered (Appendix B) and consultation took place with Occupational Health & Safety (OH&S) committees, practitioners and others with knowledge of the healthcare sector. Ten years of inspection reports from the OH&S Division were reviewed (Appendix C) as well as data from the Workplace Health, Safety and Compensation Commission (WHSCC) and the Department of Health and Community Services. These consultations were essential to learn about issues, barriers, challenges and successes in health and safety from a variety of perspectives.

The main focus of the research was qualitative in nature. Subjective data and personal opinions could not be verified within the scope of this study and it must be noted that the response rate to the employee satisfaction survey was slightly less than 20%.

Secondary research consisted of an extensive literature review from national and international researchers who have produced a plethora of material on the subject of health and safety in the healthcare work environment.

Together, this collection of data from the doers and thinkers grew into an information repository that served as the basis for the outcomes of this project. The following pages discuss that data as categorized by the key messages arising from it.

There was agreement among members of the steering committee and project partners that the final report would identify systemic issues that transcend geography and are prevalent throughout the sector. Individual organizations are neither acknowledged for successes nor branded for failure. In honouring a commitment of confidentiality, individual and organizational data sources have not been identified.

Key Messages

- Creating a culture of safety must start with an understanding of what a “culture of safety” means.
- Creating a culture of safety can be accomplished by following the lead of the province’s new Wellness Strategy.
- Creating a culture of safety requires eliminating the culture of blame.
- Creating a culture of safety involves due consideration for the role of the physical environment, the psychosocial environment and individual health practices.
- Creating a culture of safety must be recognized as a vital element of the health human resource planning process.
- Creating a culture of safety requires a “systems” approach.
- Creating a culture of safety requires industry control of health and safety.
- Creating a culture of safety requires understanding and application of the principles of the Internal Responsibility System.
- Creating a culture of safety requires application of the precautionary principle.
- Creating a culture of safety requires evidence-informed decision-making.
- Creating a culture of safety requires a focus on human factors that incorporates all elements of “safety” under one umbrella.
- Creating a culture of safety requires innovation in health and safety training.
- Creating a culture of safety requires improved communications and collaboration.
- Creating a culture of safety requires recognition of the unique needs of the community sector.
- Creating a culture of safety requires strong leadership and commitment.
- Creating a culture of safety requires increased attention to issues related to workplace violence and conflict.
- Creating a culture of safety requires the application of change management protocols.
- Creating a culture of safety requires adequate allocation of resources.

Understanding

Creating a culture of safety must start with an understanding of what a “culture of safety” means.

Most people have an understanding of the term “safety” which, in its simplest form, means “freedom from harm.” In the healthcare environment there are two distinct groups in regards to safety. The first group includes patients, residents and service recipients of the healthcare system. The second group is comprised of the “workers...and other persons at or near the workplace,” as defined by the *Occupational Health and Safety Act of Newfoundland and Labrador*.⁴

A great deal of attention has been focused on client safety in recent years. There are numerous studies linking workplace safety to patient safety; however, for the purpose of fulfilling the mandate of the Healthy Workplace Initiative, this report will focus on safety as it applies to the 18,000 workers in the provincially funded health and community services system, including those who work in acute care, long-term care and the community sector.

Clarifying the reference to safety is simple; clarifying the concept of culture is somewhat more difficult because it means different things to different people.

The literature defines “culture” as the “totality of socially transmitted behaviour patterns, acts, beliefs, institutions, and all other products of human work and thought”.⁵ With respect to the workplace, the definition of culture shifts to include “...the core clues, beliefs, and assumptions that are widely shared by members of an organization.”⁶ Organizational culture embodies the beliefs of senior executives and communicates what the organization believes in, while providing employees with a sense of direction and expected behaviour.^{6,7}

Safety culture is considered a sub-facet of organizational culture, and is a relatively new term having been introduced in a report by the International Nuclear Safety Advisory Group (INSAG) after the Chernobyl disaster.^{8,9} It is defined as being the “...product of individual and group values, attitudes, perceptions, competencies, and patterns of behaviour that determine the commitment to, and the style and proficiency of, an organization’s health and safety management.”¹⁰

Cummings and Worley suggest applying three simple questions to determine the culture of an organization:¹¹

1. What really matters around here?
2. How do we do things around here?
3. What do we do when a problem arises?

By asking these three questions in relation to the key messages in this report, a picture of safety culture in each healthcare workplace should emerge. Safety culture is not about programs, policies and safe work procedures. It is rather about the attitude and customs of a workplace that determine the impact of these initiatives. As noted by NL safety expert Wayne Pardy, “...even the most technically sound of safety programs is unlikely to work if it is forced to operate in a dysfunctional culture.”¹²

A healthcare worker used the following analogy to express her perception of safety culture during a focus group discussion: “When a workplace injury is considered as unacceptable as impaired driving, then we will have a safety culture.”

The following recommendations are intended to assist workplace parties develop an understanding and commitment to creating a culture of safety:

Recommendations

1. Co-chairpersons of occupational health and safety committees in every workplace should be assigned responsibility to review and disseminate information arising from the Healthy Workplace Initiative - *Creating a Culture of Safety*, including the findings and recommendations in this report as well as the results of the HWI provincial employee satisfaction survey.
2. Persons with responsibility for workplace health and safety at the corporate level within each Regional Health Authority should develop an accountability framework requiring that OH&S committees in each workplace develop an action plan and strategy designed to create or enhance a culture of safety by addressing the findings and recommendations in this report.

Prevention

Creating a culture of safety can be accomplished by following the lead of the province’s new Wellness Strategy.

In addition to the changes brought about by restructuring of the health and community services system, there has also been a paradigm shift toward “prevention” as evidenced by the introduction of the Provincial Wellness Strategy in 2005. The message from government was very clear: “Our province is known as one of the unhealthiest in the country and we’re committed to changing that”¹³

In announcing the new strategy, Health Minister John Ottenheimer declared:

When people think of our health system, they often focus on acute and long-term care needs. This Wellness Plan focuses on the front end of the health spectrum: overall health and wellness. The goal is to keep people healthy rather than treating and caring for them when they are ill. We know that a healthy population is a happier, more prosperous...¹⁵

The new provincial health strategy promotes a departure from the traditional medical model that emphasizes the “care” in healthcare, toward a prevention model whereby the health system assumes a new role as the navigator of well being. Hand-in-hand with this new vision is an emphasis on the benefits to be derived from collaboration within healthcare teams and among various disciplines through a multidisciplinary support system designed to prevent disease in a “keep people healthy” approach.¹⁴

Newfoundlanders and Labradorians have long been recognized for their kind hearts and unselfish efforts to rally around those in need. This proud heritage as a caring people is reflected in the healthcare system, not only in the care that is provided to the general population who enter the system as patients, residents and clients, but also in the tremendous effort that has gone into programs and services for ill and injured healthcare workers.

Efforts to develop strong return-to-work programs for ill and injured healthcare workers appear to be working! Statistics, the downstream indicators, point to positive outcomes by way of reductions in WHSCC claims duration and less reliance on wage-loss benefits. Employers, WHSCC and unions have collaborated to develop disability management programs that have succeeded in returning injured employees to the workplace in a timely manner. And while there is a tendency to focus on WHSCC claims statistics as the primary measure of success, much can also be derived from the upstream indicators as evidenced by accolades bestowed locally and nationally in recognition of innovative approaches to disability management within healthcare in NL. These are the leading indicators of success. When the numbers and the success stories are in sync, this suggests that strategies are working. Disability management programs attest to the value of multi-stakeholder collaboration. Employers, labour, public and private healthcare providers and WHSCC have come together to develop programs in early and safe return to work and attendance support that rival those found anywhere in the country.

This vital element of wellness programming is paying off thanks to the calibre of these initiatives and a dedication of resources resulting in leading-edge programming that benefits both injured and ill workers and their workplaces.

In endeavouring to make efficient use of scarce resources, most organizations have structures in place that result in some degree of overlap between the prevention and disability management functions. Since disability management is considered to be one of the many components of a comprehensive occupational health and safety program, sharing of resources would appear to be a positive move. Difficulties arise, however, when the demands associated with disability management detract from the time that can be devoted to prevention. Individuals who serve in a dual role indicate that the immediate pressing demands resulting from injuries and illness tend to take priority over

the prevention function; making it a challenge to devote equal time to proactive health and safety programming.¹⁵

Restructuring has challenged policy makers to merge systems and programs in a way that meets the needs of acute care, long-term care and community health under one giant governance umbrella. With so much change occurring, any suggestion that the time is right for an overhaul of workplace wellness strategies might not be met with eager anticipation. On the other hand, opportunity for change may never be greater.

Much can be learned by looking to the lead of the province in promoting a new vision that elevates the role of prevention strategies. A shift in focus is required that recognizes the value in pursuing a workplace goal that is aligned with that of the provincial wellness plan: to keep people healthy rather than caring for them once they are ill.¹⁶ Refusing to tolerate workplace injuries and accidents is an important step in moving toward a wellness approach.

Results of safety program strategies have not been as positive as those dedicated to disability management, as evidenced not only by absenteeism rates that continue to cost the system millions of dollars annually³ but also by directives arising from legislative compliance inspection activities, negative employee perceptions regarding physical and psychosocial working conditions, ongoing challenges with recruitment and retention, labour unrest, and shortfalls in the allocation of resources necessary to create healthy workplaces.^{16,17,18,}

This has been especially frustrating for OH&S practitioners and committees whose extraordinary efforts have not achieved outcomes that satisfy the needs of the sector nor the demands of external agencies such as WHSCC and government regulators. In fact, some cite the demands of external forces as a key factor in hampering their efforts to develop leading practice healthy workplace programming for the sector.

Research indicates that when an industry has demonstrated mastery of disability management it is positioned to relegate this function to secondary status in a move from a reactive to proactive culture¹⁹. One of the primary requirements of moving into this proactive phase is that the demands of the industry must be the primary motivation in driving program development, rather than the demands of regulators and external agencies.

Given that the province has set the stage for a new focus on wellness, the timing is ideal for creating an environment that elevates prevention to new heights by establishing program objectives that are driven by the needs of the sector and that can be accomplished from within the sector utilizing internal expertise and industry resources.

It is essential that organizations recognize the importance of dedicating adequate and appropriate resources to programming and services that may not yield the immediate cost savings of disability management programs, but that will result in greater long-term benefits in reducing accidents and injuries. Simply put, there are no quick fixes in occupational health and safety. There must be recognition of the value in program development and evidence-informed decision-making that will lend itself to moving the sector out of crisis management mode. However, there must also be recognition that such results typically take five to ten years to yield the substantial rewards that come with creating a culture of safety.

A vital first step in this endeavour is to ensure that the practice of Occupational Health and Safety is recognized as a discipline that requires the application of professional and technical expertise within an organizational structure resourced with the skill mix necessary to develop and administer a broad range of health and safety services including ergonomics, safety engineering, occupational hygiene, occupational health nursing, etc. Individuals performing a lead role in creating healthy workplaces must be competent professionals with the leadership capacity to represent occupational health and safety interests at the corporate table. Persons performing vital work in developing and administering health and safety services must have the expertise to make informed decisions and they must be afforded the opportunity to keep their technical skills and knowledge base current.

Historically, there has not been a clear distinction between the skill sets required to administer disability management programming and that of prevention. This is particularly true of ergonomics where there is currently no single program of study or regulated profession dedicated to the discipline of ergonomics, nor a legal requirement to obtain professional certification as a license to practice. While the opportunity to obtain professional certification exists in Canada, this requirement has not been adopted in healthcare human resource hiring policies. This may explain why most healthcare organizations within the province have developed a reliance on rehabilitation professionals to develop and administer ergonomics programming, based on an assumption that qualification in a regulated rehabilitation profession equates to ergonomics expertise. Although clinical occupational therapists and physiotherapists may have large rehabilitation caseloads making it difficult to pursue attainment of other skill sets, they are often called upon to function as ergonomists. Some persons within these professions are indeed competent ergonomists, having supplemented their formal education with post basic ergonomics training and hands on experience, but there is no standard requirement to do so.

The term “ergonomics” has also become synonymous with “soft tissue injuries” and this too has led to a somewhat limited focus. In reality, ergonomics encompasses much more than prevention of soft tissue injuries. It is a scientific discipline that addresses issues related to human factors in terms of

physical, biological, behavioural and cognitive functioning, and how these factors interplay to create a healthy fit with the environment.

Because of the wide scope of ergonomics, the academic background of an ergonomist can vary widely. An ergonomist may have a degree in psychology, engineering, medicine, kinesiology, computer science, physiotherapy, occupational therapy or similar discipline; however, none of these backgrounds alone is enough to make someone an ergonomist. Ergonomists need to have specific education and training in ergonomics methods, theory, concepts, and principles that comes from electives and courses that are outside the standard courses offered in most academic programs.⁷⁰

A similar situation exists in relation to the recognition, evaluation and control of biological and chemical hazards within the healthcare work environment, with very few organizations having recognized the need for occupational hygiene expertise, choosing to assign such responsibility to infection control practitioners, facilities personnel and others.

In addition to the level of knowledge and expertise required to function effectively as an ergonomist or occupational hygienist, other disciplines have gained recognition as specialty areas within the practice of occupational health and safety including safety engineering and occupational health nursing, each having technical competencies that are vital to the development and implementation of a broad range of health and safety programs and services. Industries that have been successful in creating a culture of safety are those that have recognized the professional and technical expertise required to administer the broad scope of practice that falls within occupational health and safety.

There must also be recognition that persons employed in the practice of occupational health and safety function in a technical and supporting role to augment the efforts of all workplace parties in carrying out their responsibilities for creating safe and healthy workplaces. They are not the “doers” of health and safety; any more than infection control practitioners are the “doers” of infection control, yet there appears to be somewhat of a perception that the role of an OH&S professional is one that equates with inspection and enforcement rather than technical proficiency and strategy development.

During a focus group discussion regarding health and safety responsibilities of various workplace parties, one manager offered this viewpoint: *“I can’t take on a role of following staff around but I can create the right safety environment.”*

OH&S committees must also be recognized for the important role they play in the creation of healthy workplaces and they must be structured to meet the

requirements of each individual workplace. Legislation provides minimum standards for the structure and functioning of OH&S committees but they are just that - minimum standards. Due to the complexity and size of many healthcare organizations, this minimum standard may not be sufficient to permit committees to operate at a level that makes best use of this valuable resource. There may be a need to form supplementary committees or working groups with responsibility for a particular function or work area that report directly to the legislated committee required under the OH&S Act. These sub-committees can be assigned responsibility for such things as inspections, program development, training and communication or they can be created within a particular department or functional area.

When OH&S committees were surveyed about their functions, successes, needs and challenges, many indicated a need for access to timely information, technical expertise and advice. Several suggested that a central resource dedicated to healthcare health and safety would be of tremendous benefit in fulfilling their responsibilities.

Elevating occupational health and safety services to an increased level of importance, guided by informed, professional expertise and committees that are adequately resourced and supported in their efforts is a vital step in the creation of a culture of safety.

Recommendations

1. The prevention function should be separated from the disability management function in terms of resource allocation and/or corporate structure. This can be accomplished by administering disability management programming under the direction of Human Resources Departments while aligning workplace health and safety programming under the administrative structure responsible for other risk management functions.
2. Adequate funding should be provided to ensure that occupational health and safety departments and committees are provided with the resources necessary to produce quality services and programs including paid time for committee members to devote to occupational health and safety activities as required.
3. Standards should be developed that support and encourage ongoing professional development for OH&S personnel with emphasis on the knowledge, experience and academic qualifications necessary to attain an appropriate profession designation, including:
 - Canadian Certified Professional Ergonomist (CCPE)
 - Canadian Registered Safety Professional (CRSP)
 - Certified Occupational Health Nurse (COHN)
 - Registered Occupational Hygienist (ROH)
4. Research opportunities should be provided for those in the practice of Occupational Health and Safety in order to facilitate evidence-informed

- decision-making based on sound knowledge, timely information and the precautionary principle.
5. OH&S department structures and hiring practices should be reviewed to ensure that appropriate skill mix is utilized to effectively develop and administer all elements of OH&S programming. This may require realignment of responsibility among various disciplines or amendments to position qualifications.
 6. The terms of reference and performance of each OH&S committee should be reviewed by senior administration to determine if appropriate structure and support is provided to allow committees to fulfill their mandated responsibilities as determined by legislation, policy and needs of the workplace.
 7. A central resource should be established to provide consultation, advice and technical expertise to OH&S committees and practitioners as a supplement to internal workplace resources.

Blame

Creating a culture of safety requires eliminating the culture of blame.

“Using safety program elements in the wrong culture is like using a perfectly good electrical appliance under water. The electrical appliance is fine ... the environment is all wrong.”

~ Dr. Dan Petersen

“Culture of blame” as cited in the patient safety literature describes reluctance of healthcare professionals to report adverse client-centered events out of fear of reprisal or assignment of blame at the level of the individual worker.^{20, 21}

While there may be isolated incidents where reporting of worker-centered events is impacted by perceptions of fault finding, this does not appear to be nearly as pervasive in relation to workplace safety. In fact, avoidance of blame is well entrenched in occupational health and safety ideology and healthcare organizations have expended tremendous effort in developing hazard and incident reporting processes that encourage workers to report all occurrences; including near misses and hazards with the potential to create harm.

However, a culture of blame of a different variety appears to exist within NL’s healthcare workplaces. This culture of blame is not found so much at the level of the individual worker as it is by way of a collective assignment of responsibility for the existence of unhealthy work environments.

This attitude factored prominently in focus group discussions revealing an “upward blame” for responsibility regarding deficiencies in the physical environment. When hazardous conditions in buildings and equipment are not corrected in a timely manner, workers blame managers, managers blame

corporate leaders, corporate leaders blame government. The reverse is also true in assignment of “downward blame” with regard to accident and injury rates. Each level of authority looks to the next lower level for answers as to why prevention efforts are not producing more positive results in reducing accidents and injuries, suggesting a belief that someone “further down the line” is not doing what they should be doing.

Culture is largely impacted by communications. In a safety culture, there is a free exchange of information. Workers are encouraged to identify and report hazards, concerns are addressed in a timely manner, and feedback is provided about how concerns are addressed. When communication is friendly and there is no evidence of intimidation, employees are more inclined to work with the organization to achieve common goals.

Likewise, when workers display a willingness to co-operate with the employer in a sincere desire to problem-solve in the absence of an adversarial approach, the employer is more likely to consult with them on a regular basis.

In an environment as broad and diverse as healthcare, it can be extremely difficult to keep everyone adequately informed about progress on a particular issue. Employees typically have no knowledge of what is taking place at the corporate level, nor do they know about the complications that can delay the timely resolution of problems, so when they don’t see results and they haven’t been kept in the loop, they surmise that their concerns have fallen on deaf ears. Likewise, as organizations grow in size, and managers’ span of control grows accordingly, it becomes more difficult for corporate leaders, middle managers and even frontline supervisors to keep apprised of the myriad of issues impacting the work environment on a day-to-day basis.

When asked to rate the importance of safety in the workplace from an organizational perspective, one manager provided this response: *“I would give it a 9 out of 10 but if I was an employee I would probably say 4 because we see things that are happening but employees don’t.”*

How people respond to lack of communication and a perceived lack of action may take on many forms depending on personality, position, working relationships, history, etc. Some people are outspoken and talk negatively to anyone who will listen, some seek revenge by feigning illness or injury and calling in sick, and others become complacent. What is particularly alarming is that some appear to have adopted an attitude that serves to create unnecessary risk, as revealed by the comments of this worker:

“Why should I take the time to use a mechanical lift when they won’t fix the lousy ventilation system?”

If this sentiment is shared by others, it is likely to manifest itself in the “we / they” attitude that is widely regarded as a cornerstone of the culture of blame that epitomizes an unhealthy workplace.

This can be changed, however, as evidenced by this observation:

“Our building is old, hot and dilapidated and it certainly isn’t getting better with age. But last year our manager introduced policies that make our work so much easier like open-back clothing and individual slings for every resident. Since then, the building doesn’t seem nearly so bad.”

Research suggests that there must be transparency, accountability, open communications, collaboration and mutual respect in the workplace in order to overcome a culture of blame and create a culture of safety.

Recommendations

1. OH&S committees should be engaged in the process of providing ongoing communications regarding workplace health and safety programs and services.
2. Adequate communications processes must be a part of the hazard identification, evaluation and control process.
3. Health Authorities should determine, in conjunction with OH&S committees at each site, the most appropriate and effective means of communicating feedback on control measures being undertaken to resolve identified hazards, particularly those that may be subject to delays in implementation.
4. Corporate communications departments should be engaged to identify innovative and effective means of communicating OH&S policies, programs, committee minutes, hazard alerts and safe work procedures throughout each organization.



Healthy Workplace Model

Creating a culture of safety involves due consideration for the role of the physical environment, the psychosocial environment, and individual health practices.

Research provides ample evidence that the health of workers has a powerful effect on the workplace and the workplace has a powerful effect on the health of workers.²² For decades, Health Canada has approached the issue of health

in the workplace in a comprehensive and integrated fashion by looking at the key factors that affect employee and organizational health, determining them to be:²³

- The physical work environment.
- The psychosocial work environment.
- Health practices.

This definition of what constitutes a healthy workplace has been front and centre of all research activities undertaken by *Creating a Culture of Safety*.

The physical environment is comprised of buildings, equipment, air quality, space, heat, noise, lighting, physical layout, chemicals, flooring, infectious agents, workstations, tools, etc. The psychosocial environment includes such factors as working relationships, recognition, perceptions of fairness, training, job design and communications. “Health practices” refers to behaviour of individuals in terms of sleeping habits, smoking, diet, physical activity, medication usage, and alcohol consumption. Research now tells us that these factors do not exist in isolation. They are directly or indirectly related, and impact the health and productivity of both employees and the organization.

Physical Environment

In terms of the physical environment, healthcare work settings consist of a multitude of buildings, systems, and equipment as well as thousands of workstations spanning many departments and a broad range of healthcare services. It is impossible to comprehend the tribulations associated with providing and maintaining the physical infrastructure within such a system.

Older buildings and equipment in NL healthcare workplaces present their share of challenges, particularly those that now serve a different clientele or provide a service that bears little resemblance to their originally intended purpose. The fact that the system has done as well as it has in adapting the infrastructure to meet the demands of a constantly evolving system is a credit to government and the health authorities. Given the challenges and complexities that go along with maintaining older infrastructures, it is not surprising that less than ideal conditions can be found in some facilities and that there is frustration with the amount of time it takes to have unsafe conditions rectified. Survey results show that 65% of employees are satisfied with the physical work environment, yet the survey summary lists concerns with the physical environment as a general theme arising from survey comments, stating “*there needs to be improvements made to the physical environment such as space, temperature control, air quality and equipment.*”

While it was not surprising to learn of deficiencies in older buildings, it was very surprising to realize the level of dissatisfaction that exists with the physical environment as expressed by workers in newer facilities. Issues

related to inadequate storage, poorly designed workstations, unsuitable equipment, cramped workspaces and impractical traffic flow were identified frequently as concerns during focus group discussions. It was also disconcerting to learn that the same deficiencies have been repeated numerous times.

In recognition of this, the Ergonomics sub-committee established by the Healthy Workplace Initiative undertook efforts to address issues related to the design of healthcare facilities. This was determined to be a timely undertaking since planning and design activities are currently underway for twelve facilities at various locations throughout the province. One of the committee's activities involved providing information to key groups identified as playing a significant role in the design and construction process and by promoting a participatory ergonomics approach that fosters meaningful consultation with workers and ergonomics experts. Applying this concept to all stages of the facility planning process can be expected to have significant long-term benefits such as those realized by Interior Health in British Columbia, where an ergonomist position has been dedicated full time to serve as a consultant in the facility planning, design and maintenance process.²⁴ Perhaps there is much to be learned from examples like this, since only 36% of survey respondents indicated satisfaction with the level of input they have in the planning process.

The planning and consultation process must be recognized as a vital step in creating healthy healthcare workplaces, not only in relation to the design of new buildings but in ongoing consultation regarding equipment selection, workstation design and other areas where a collaborative approach involving workers, ergonomics experts, managers, purchasers and OH&S professionals can positively impact working conditions. This process can be enhanced by recognizing the value of applying a human factors approach to all aspects of the workplace, including both the physical and psychosocial environments.

Psychosocial Environment

While issues with the physical environment factored prominently in focus group discussions, it is fair to say that they paled in comparison to time spent discussing psychosocial and organizational factors. Foremost among the concerns expressed by workers and managers were lack of communication and feedback, inadequate staffing levels, strained interdisciplinary relationships, internal conflict and time constraints.

Workplace attitudes towards safety garnered much discussion, particularly the perception that support for workplace health and safety is superficial. According to the literature, this perception regarding the absence of a sincere desire to create healthy workplaces is a significant determinant of safety culture.^{10, 12} To quote a focus group participant: "*Safety is talked about but not addressed.*"

According to the employee satisfaction survey analysis, a picture emerges that suggests room for improvement in terms of the psychosocial environment. Overall, 60% are satisfied with the culture and supportive environment with just over half (53%) feeling that management cares about employees. This serves to corroborate similar data obtained from focus group discussions.

As one means of researching the correlation between safety culture and the psychosocial environment, an exercise was conducted that was borne out of a study by Koehoorn, Lowe, et al in which participants were asked two simple questions:²⁵

1. Is this a safe place to work?
2. Is this a great place to work?

Results from this study resulted in the conclusion that there is a direct correlation between employee perceptions of what constitutes a safe workplace and what constitutes a great workplace. The telltale feature of the exercise was not whether workers answered yes or no to individual questions, but rather the number that gave the same answer to both. The exercise was mimicked during focus group discussions, and produced results similar to those of Koehoorn, with over 80% of participants providing the same answer to both questions. This suggests that perceptions of safety are impacted by how satisfied a worker is with other elements of the workplace, particularly those of a psychosocial nature. While the sample size was small, the results support data obtained from other sources, leading to a conclusion that psychosocial factors may have a significant impact on efforts to create a culture of safety.

Communication is one of the psychosocial elements that factors prominently in attitudes about safety culture, with just over half of survey respondents (53%) agreeing with the statement *“Management communicates regularly and effectively with employees.”*

Teamwork and cooperation are also significant determinants of safety culture. 60% of survey participants responded positively to the survey statement *“There is a culture of teamwork and cooperation at my place of work.”* Focus group participants expressed a similar mix of sentiments on this issue.

“I think we are so caught up in fear, anger and animosity that we can’t see past ourselves. We don’t work together like we used to.”

“There is no teamwork here.”

“Everyone pulls together and we make a great team!”

During the past twenty years, there has been a dramatic increase in the frequency of soft tissue injuries in almost all industries, with healthcare faring

worse than most. This is often attributed to the inadequate fit between workers and their physical environment, resulting in awkward postures, repetitive movements and overexertion.

While there is no doubt that the physical environment does play a significant role, research is now looking beyond the physical environment in relation to soft tissue injuries. The literature identifies psychosocial issues as factoring prominently in injury statistics and has determined that organizations with strong safety cultures as epitomized by positive working relationships, perceptions of fairness, open communications, routine consultation and a happy workforce consistently report fewer injuries than organizations with weak safety cultures.^{59, 71}

Graham Lowe, Grant Schellenberg, Linda Duxbury and Martin Shain are just some of the many researchers who provide evidence to suggest that an unhappy workforce is an unhealthy workforce.²⁶

Former Canadian politician and world-renowned speaker Stephen Lewis noted the importance of this during an address at a National Leaders' Forum in Canada in 2005:

“...It’s the lesson in life that I cherish most; that the best collaborative spirit, the best quality of interdisciplinary collaboration, which makes it work, is to acknowledge the work of your colleagues. It is so fascinating to me, after more than 20 years in the multilateral system, to see how incredibly begrudging leaders are about acknowledging the work of their colleagues. And there is nothing that means more to colleagues than to have the very significant work that they do acknowledged, treasured, celebrated, recognized --- and we’re so curmudgeonly about it. We’re so reluctant to confer on people who do the basic work, whether it’s the basic science or the basic front-line interventions, we’re so reluctant to confer on them the praise and the recognition which they deserve and which makes collaboration possible. If one wants to create a collaborative environment, then set immediately a standard of recognition so that everybody feels worthy, and so that everybody feels merited.”

Traditionally, healthcare organizations have relied upon formal written performance appraisal systems to facilitate discussion about job performance, including use of safe work procedures, adherence to health and safety policies and job satisfaction. But there are limitations to this type of communication tool including the fact that they often get overlooked. Only 47% of survey respondents provided a positive response to the statement *“My performance is reviewed at least annually.”* In fact, many respondents indicated that it is not unusual to work in excess of ten years without receiving a performance appraisal.

Acknowledging safe practices and reinforcing the importance of safety is too important to be left to this type of mechanism, yet when focus group participants were asked how safe work is acknowledged, they had difficulty citing other methods by which this occurs.

A manager who regards safety as a high priority should use communications activities on health and safety as a routine part of daily management activities; however, given the span of control that exists for managers in a complex, multi-site structure, this can be a challenge, particularly in a 24/7 operation. Providing timely information about performance, unsafe conditions, and health and safety programming activities can reap tremendous benefits for the workplace and its workers.

The ever-changing nature of the healthcare environment also demands regular evaluation of work processes to ensure optimal utilization of human and financial resources. This too should ideally be a routine function of operational managers, working in collaboration with affected disciplines, to ensure that issues related to efficiency, demand/control, skill mix and job satisfaction are addressed in a timely manner. Unfortunately, such evaluations are time-consuming and indications are that they do not get completed as often as they should. As a consequence, some departments or programs may continue to operate with processes and systems that have not kept pace with changes in technology, equipment, client base, service needs, demographics and worker abilities. Work practices sometimes continue unchanged for many years, possibly because change does not come easily and there is comfort in doing things as they have always been done. This results in acceptance of the status quo as an adequate standard while creating frustration among workers whose skills may not be utilized to maximum capacity, those who feel they should be more in control of their job function or those who are aware of more effective methods of performing their duties or providing a particular service with greater efficiency.

Such circumstances can have a negative impact on workers whose skills are underutilized or those subject to low control/high demand work situations. According to research, role stress will arise from a disparity in what an individual believes to be the specific characteristics of the job role and what they are actually achieving in that role. When achievement is lower than role expectations, role stress is the result, leading to higher rates of accidents and injuries, more sick leave and job dissatisfaction.

The healthcare system relies so heavily on its human resources that it cannot afford to have workers who perform at less than maximum capacity. The best possible utilization of the skill sets of various disciplines is of vital importance. Research suggests that this will result in not only greater employee satisfaction and program efficiencies but in a reduction in absenteeism as well.

It is important to recognize that health and safety hazards and risk levels vary in different settings and are impacted by many physical and psychosocial factors. However, there are a number of broadly held opinions about what is required to create healthy workplaces that factor prominently throughout most of the system, most notably issues related to staffing and scheduling. When asked about what needs to be done to create safe and healthy workplaces in healthcare, the number one response from focus group participants was, without question, “*more staff.*”

It is possible that the broadly held opinion regarding inadequate staffing levels can be attributed partly to factors in the psychosocial environment as well as to actual staffing allocations since research indicates that perceptions of inadequate staffing are commonplace in workplaces demonstrating an unhealthy safety culture. Meanwhile, if staffing allocations are based on a predetermined formula such as caregiver to client ratios and square footage of cleaning services required, this can be problematic unless there is some means of accounting for variables that have a direct impact on safe working conditions. Factors such as age and condition of infrastructure, workforce demographics, complexity of service, geography, impact of technology, effectiveness of hazard controls, shift work and other factors should also be reflected in safe staffing level formulae. Restrictions imposed by collective agreements and staffing policies also create impediments to scheduling flexibility that can impact staffing levels along with extremely high absenteeism rates and generous leave benefits.

Restructuring of the healthcare system in NL in the 1990’s resulted in the elimination of approximately 100 management and supervisory positions. Those left behind were faced with added responsibilities and a broader span of control in relation to the number of subordinates reporting to each manager. According to the literature, this is a significant factor in the management of workplace health and safety.²⁷ Increase in span of control can have negative ramifications for both workers and managers if it increases stress levels, impedes communication and diminishes contact with work units, lessening the ability to stay informed about workplace hazards. There are also studies indicating that there can be positive outcomes to this type of downsizing if well designed restructuring plans make provision for flatter organizational structure by way of greater worker participation in decision making, improved collaboration and better role clarity.²⁸ Many managers expressed dismay that such a plan is not in evidence and they spoke of workloads that leave them feeling overwhelmed and overburdened.

There is no doubt that the psychosocial health of a workplace is a significant determinant of safety culture. This is very significant since it is broadly accepted that efforts to control health and safety conditions in the physical environment will not likely achieve optimal results if the same level of attention is not given to psychosocial work factors. Since there is evidence to

suggest that organizational restructuring can significantly impact the psychosocial health of a workplace, healthcare organizations would be well advised to review lessons learned from past restructuring efforts along with corporate mergers in other jurisdictions and industries as they formulate their strategic plans.

Individual Health Practices

Many workplaces have established health promotion programs that focus on individual health practices under the banner of “employee health” with a focus on healthy lifestyle choices. While many programs are offered during working hours, there is little focus on working conditions. Most program elements target individual employees by offering assistance with smoking cessation, weight loss, stress management and physical fitness. Few appear to make provisions for the restrictions or impact of shift work.

In 1994, former Prime Minister Jean Chrétien launched the National Forum on Health that, among other things, resulted in a working group being struck to explore issues related to “Determinants of Health”. The Determinants of Health Working Group Synthesis Report states:²⁹

“There has been a great deal of discussion about the importance of personal health practices for the health of individuals and populations. While we have known for some time that poor health practices (such as smoking, poor eating habits or substance abuse) are determinants of ill health, we now know that such practices are very much influenced by the social and economic environments in which people live and work. They involve less of an individual choice than was once thought.”

There is a growing body of research surrounding health promotion programs. Workplace health gurus such as Graham Lowe recommend that health promotion programs should expand their focus to address the underlying causes of ill health and injury, not just the symptoms, suggesting that many of the underlying causes are rooted firmly in the workplace. A growing number of workplace health professionals agree, recognizing that changes in job design and workplace culture can impact individual health practices.

Several studies have looked at psychosocial stressors in the health environment, primarily from a nursing perspective.^{30,79} What they have determined is that a healthy workforce is about more than employees eating wholesome foods, drinking responsibly and getting lots of exercise. With low morale being widespread throughout healthcare workplaces, more and more researchers are recommending that health promotion programs focus on elements designed to coax feedback from employees, to encourage more communication, provide work recognition and give employees a feeling of inclusion in the organization.³¹

The concept of healthy workplaces has evolved dramatically over the years. The first wave focused on the basics of creating a safe workplace in terms of the physical environment. It then grew to include positive wellness, which led to the introduction of health promotion programs. The third and current wave endeavours to create a culture in which employees feel good about coming to work by addressing work-life balance, fatigue management, healthy working relationships, employee engagement and morale.⁶³

Researcher Graham Lowe challenges practitioners in health promotion and OH&S to redefine their roles in the organization by contributing directly to the overall mission of the organization through a broader approach that recognizes the connection between work and individual health practices.⁴⁹

Other researchers offer a similar challenge to organizations, suggesting that the interplay of work and family and work and self are inexorably intertwined and play a significant role in creating healthy workplaces.³² One study suggests a link between absenteeism and high levels of job strain, job dissatisfaction and psychological distress and that work stress is related to ill health, connecting a poor psychosocial work environment and increased incidence of illnesses among workers including three times more heart disease, five times more cancers of certain types, three times more back pain, two to three times more conflict, mental health problems, infections and injuries.^{34,59,63}

In British Columbia, the Occupational Health and Safety Association for Healthcare (OHSAH) is currently involved in a Healthy Workplace Research Initiative entitled "*Changing the Work Environment: Improving the Mental Health of Hospital Workers.*"³³ In the fall of 2006, a report was issued outlining the findings of the research from Phase I, indicating that over 60% of frontline healthcare workers report experiencing burnout, depression, anxiety, and irritability in response to work stressors. The report further indicates that the most frequent outcome of this work related stress is increased sick time, short-term disability, and long term disability. This is significant in that it suggests that the lines between work-related absences and non work-related absences are blurred, meaning that in addition to workplace injury statistics that have traditionally measured the impact of work on the health of workers, there must also be provision for factoring sick leave statistics and long-term disability claims into that equation.

Many studies have explored the link between safety culture and work-life conflict. Research tells us that there is often a gap within organizations between formal work-life policies and informal practices which make balance difficult and which may be hidden in sick leave and injury leave statistics. Work-life balance is an area where HWI survey scores showed one of the highest satisfaction rates (80%), yet there was a great deal of focus group discussion regarding staffing practices in relation to work-life conflict. Workers expressed much displeasure about what they describe as routine denial of

annual leave or delays in approving such leave, creating difficult choices between work and family commitments. Many readily acknowledged that when family commitments are on the line, they learn quickly to avoid work-life conflict situations by calling in sick or reporting a workplace injury since this type of leave is not subject to refusal.

The Health Canada model of what constitutes a healthy workplace is one that should be adopted throughout the entire healthcare system with equal and appropriate attention to the physical environment, the psychosocial environment and individual health practices. The following recommendations are intended to address each of these elements.

Recommendations

1. Hazards in the physical environment must be identified, evaluated and controlled by the most efficient and effective means in all workplaces without delay.
2. Maintenance work order systems should be designed to prioritize work relating to the control of unsafe conditions and track the amount of time it takes to have deficiencies corrected. Monthly reports should be generated for review by senior administrators and OH&S committees.
3. When new facilities are to be constructed or existing buildings to be renovated, there must be consultation utilizing a participatory ergonomics approach involving workers, managers, OH&S professionals and ergonomists. Ergonomics expertise must be consulted at every stage of the process, including schematic design, contract documentation, construction, and post-occupancy evaluation.
4. Methods must be identified for assessing and adequately controlling managers' workloads and span of control.
5. Human Resources departments should explore alternatives to the traditional performance appraisal process for providing feedback to employees.
6. Employers should develop and track indicators to measure activities impacting the psychosocial work environment in each department or work unit, including:
 - a. Paid and unpaid overtime for workers and managers.
 - b. Employee turnover.
 - c. Staff meetings (frequency, topics, outcomes, attendance, etc.)
 - d. Number and type of referrals to employee assistance programs
 - e. Total absenteeism of all types
 - f. Grievances (frequency and trend analysis)
 - g. Work refusals
 - h. Concerns referred to the OH&S committee
 - i. Education activities including attendance and impact evaluations
 - j. Disciplinary actions
7. Appropriate support must be provided for employees who work rotating shifts. This includes implementing fatigue management systems and reviewing human resource policies to determine if they are compatible with a complex 24/7-work environment.

8. Health promotion services should be expanded to include relationship-oriented health promotion strategies and quality work-life issues.
9. Employers and labour groups must work together to develop strategies to address the dissatisfaction and disengagement that is prevalent among healthcare workers.



Human Resources

Creating a culture of safety must be recognized as a vital element of the health human resource planning process.

Health Canada's Health Human Resource Strategy includes a focus on recruitment and retention aimed at encouraging more people to enter health professions and improving working conditions to entice them to stay. The NL Health and Community Services Human Resource Planning Unit (HRPU) was established under this strategy to assist healthcare employers in recruitment and retention efforts.³⁴

The HRPU represents a partnership agreement between the provincial Department of Health and Community Services and the NL Health Boards Association. Since its inception in 1999, the HRPU has collected, analyzed and disseminated key provincial health workforce data in a report platform designed to assist in the development of human resource planning strategies.²⁴

Reports generated by the HRPU provide a timely and consistent source of workforce supply indicators such as age-based retirement projections, worked-to-earned ratios, workforce movement, vacancies, and other important data vital to the development of strategies that traditionally drive recruitment and retention efforts.

In addition to compiling and analyzing statistical data, HRPUs reports offer observations on a number of issues relating to workplace wellness and culture as revealed by the following excerpts from the NL Health Human Resource Indicator Report 1999 to 2003:³⁵

“A complete analysis of workforce wellness would include health and safety initiatives, and physical and emotional health of an organization. This report was limited to workforce wellness as characterized by injury leave, sick leave and grievance rates.”²⁵

“The number of grievances generated by employees could be considered as a proxy measure of employee satisfaction... Eight out of ten health boards reported that grievances were being generated faster than they were being resolved or dropped.”²⁵

“Understanding reasons for turnover is essential for effective health human resource planning, including the recruitment and retention of staff.”²⁵

Examination of these issues falls outside the mandate of the HRPUs whose primary objective is to build a solid base of data upon which projections and key human resource policy decisions can be made. By highlighting issues related to workplace culture and job satisfaction, the HRPUs has challenged the healthcare system to conduct further research into the deeper issues behind absenteeism statistics.

This shows a need to expand the scope of human resource planning strategies from one of forecasting for future recruitment efforts to a broader focus that includes developing policies designed to create an environment that contributes to worker satisfaction and well-being as a crucial element of retention efforts. A key component of this endeavour is an immediate examination of human resource policies, programs and practices to determine their impact on workplace wellness.

The healthcare system is changing; so too is the demographic from whom the pool of health human resources is drawn. As baby boomers make way for a new and less plentiful generation of workers, the system must ensure that programs and practices are designed to keep pace with their needs, choices and demands that includes a healthy and supportive work environment.

Positive initiatives have been established in many healthcare work environments and were acknowledged by focus group participants:

“This organization has an employee assistance program that has done so much for so many. It means so much to know that there is help when you need it most.”

“The flexible work schedule we have is very positive in balancing personal /family needs with work requirements.”

According to workplace health and productivity consultant Dr. Mark Tager, these types of policies are vitally important since the good old days of stable jobs, ample manpower and consistency in the workplace are gone, leaving many workers feeling stressed, distracted, out of the loop and battling a current of constant change.³⁶ Does this apply to healthcare workers in NL? Do they feel stressed, distracted, out of the loop and constantly battling change?

Results from the employee satisfaction survey provide information to suggest that this may indeed be the case, with 53% of respondents indicating that their work is too stressful. And while there is appreciation for strategies and policies designed to reduce stress and enhance quality of work-life, managers and workers have also identified various workplace policies that they consider as contributing to workplace stress. A number of policies were cited that are viewed with suspicion and displeasure and appear to be having a serious impact on workplace culture. Policies that factored prominently in discussions were likely initiated with the best interest of the workforce and the workplace at heart; however, given the level of negative perception among workers; it appears they may be seriously impacting workplace health, safety and productivity as evidenced from anecdotal data.

“Our facility is old and not equipped with air conditioning...it is hot and stuffy during the summer. I think we should be allowed to wear sandals to help us feel a little cooler; however, our dress code prohibits this...”

“When I first started here, every Christmas, we would have a hot turkey dinner served to us by our managers. That went on for a few years and it was lovely. It made us feel appreciated. Then it became turkey roll, potato, and gravy. Then it was a cold plate. Now we don’t get anything. It makes you feel really unappreciated...”

“Last year I took two sick days because I had the flu - there was no way I could work. However, at the end of the year my organization made the decision to send a letter to each employee who had perfect attendance for the year. A woman on my unit had maxed out her sick leave the year before - she cannot take any more - got a letter congratulating her on perfect attendance and a job well done, but I didn’t! Can you imagine how that made me feel? I took two days off for a legitimate reason, while this person, who has taken a sick day every time she didn’t feel like coming in to work, was rewarded. Well I can tell you now - the next day I called in sick!”

“I moved here from another province where I received three weeks of orientation, of which three full days were devoted to safety and safe work procedures. I came here in the same job and got three days of orientation in

total with no mention of safety or safe work procedures. When I brought it up, I was made to feel like a troublemaker.”

The perceptions, attitudes and opinions of leaders, managers, and staff about what they believe to be true about their work environment and their relationships can have a significant impact on safety culture. Organizational-change experts contend that it is not official policies that drive organizations but rather the unwritten rules.³⁷

Reality is that the healthcare workforce is shrinking. Already there are shortages of physicians, pharmacists, lab and x-ray technologists and tradespersons, with many others on the horizon.^{18,19,20}

Another reality is that the healthcare workforce is an aging workforce.²⁵ It is also comprised of workers who have been accommodated due to workplace injuries and those who suffer from the cumulative effects of physical and psychosocial job strain.

In some parts of Canada, government and employers are encouraging workers to delay retirement in an effort to retain experienced workers as one solution to dealing with labour shortages. One such program is the Late Career Nurse Initiative developed by Ontario’s Ministry of Health and Long-Term Care. This program *“recognizes that many late career nurses wish to remain in the workforce, but the physical demands of full time point of care nursing pushes them towards retirement. This initiative provides funding for nurses over the age of 55 to work in alternate roles for 20% of their time.”*³⁸ While no such interventions have been implemented yet in this province, the elimination of mandatory retirement provisions could result in a need for such innovation.

The National Federation of Nurses Unions (CFNU) also recognized that issues related to recruitment and retention of experienced workers was becoming a timely issue when they launched the “Experienced Nurse Project” as one component of a Healthy Workplace Initiative to study issues that impact employment of experienced workers.³⁹ Recommendations from that project focus on providing flexibility in scheduling, work arrangements, and workplace practices, as well as respect and recognition, professional development, skills development and training, mentoring, management structure adjustments, pre-retirement and post-retirement strategies.

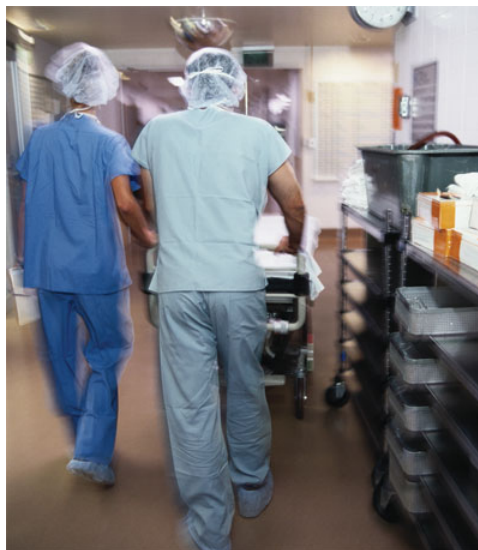
These recommendations can be applied to disciplines other than nursing; therefore they should be reviewed by all organizations to determine if there is value in incorporating them into human resource planning strategies.³¹

Creation of a healthy workplace culture will help organizations move forward with successful interventions aimed at increasing capacity for recruitment and

retention of a happy healthy workforce, leading to creation of a culture of safety.

Recommendations

1. Human resources personnel should consult with workers, managers, OH&S committees and labour representatives at each workplace to determine priority actions required to create a culture of safety, including:
 - a. Conducting impact evaluations to determine if longstanding policies are achieving the intended results.
 - b. Conducting exit interviews with terminating and transferring employees to solicit their input on working conditions and job satisfaction in terms of both the physical and psychosocial environment.
 - c. Developing formal career path goals early with individual employees in disciplines that are subject to high rates of stress, burnout and injury.
 - d. Reviewing innovative retention policies from other provinces and industries.
 - e. Reviewing orientation policies on training in safe work procedures and hazard identification, evaluation and control.



System

Creating a culture of safety can benefit from application of a systems approach.

There is no denying that healthcare workers perform work that is physically and emotionally demanding. Statistics from across the country reveal rates of injuries and illness exceeding those of other industries traditionally recognized for the hazardous nature of their work.⁴⁰ Since client handling is cited as the single greatest source of injury, there has been an emphasis on safe work procedures designed to control hazards contributing to the ailing backs, necks and shoulders of healthcare workers.

When focus group participants were asked about health and safety programs in their workplaces, “BIPP” inevitably came up. Even in organizations where the original *Back Injury Prevention Program* (BIPP) has long been replaced, renamed or revamped, many experienced workers still refer collectively and without hesitation to soft tissue injury prevention programs and safe client handling procedures as “BIPP”.

Back Injury Prevention Program

Developed in the early 1990’s, BIPP introduced mechanical lifting devices and safe work procedures that had been previously unknown in NL and in much of Canada.⁴¹ This leading edge program was three years in the making and set the standard for other provinces to follow.

BIPP was a comprehensive system, made up of many elements, each intended to work together in an all-inclusive program at the centre of which was a focus on integration of person, training, management support, and job demands.⁴² BIPP was acknowledged and supported as a credible program with the potential to positively impact accident and injury rates. As anticipated, initial results were very positive. Injuries to the lower back, which had long been the leading cause of lost time, went on a downward spiral. Unfortunately, the success was short lived and within seven years, injury rates began a slow and steady rise that peaked in 1999 at 3.83 injuries per 100 employees per year and has remained close to that level ever since.⁴³

So what went wrong? Why was the early success of BIPP not sustainable? While limited research has been conducted, a full-scale retrospective causal analysis has not been undertaken, limiting reasons for the short-lived success of BIPP to speculation. BIPP was introduced during a time of severe fiscal restraint, followed by the first round of major restructuring of the healthcare system. As a result, the program was never introduced in its entirety on a provincial basis. Instead, individual organizations selected the elements determined to best suit their needs and budgets, with primary emphasis on training and equipment, most notably the introduction of mechanical lifting devices and “BIPP training” involving body mechanics and safe client handling procedures. The program elements that suffered were those designed to ensure sustainability, including processes for routine monitoring, impact analysis and evaluation. Another factor cited by some as contributing to BIPP’s short-lived success may have been the elimination of a dedicated central resource to provide coordination, cohesion, and consultation services.

Had BIPP been implemented as a complete system utilizing its full potential, it could have encompassed the many hazard categories that contribute to healthcare being compared to mines, factories and police work in terms of danger⁴⁴. With ever-present risks from exposure to aggressive clients, toxic chemicals, infectious agents, blood-borne pathogens, compressed gas, emotional stress and more, healthcare is indeed a risky environment in which

to earn a living.⁴⁵ This is reflected in the broad range of hazards identified during healthcare inspection activities conducted by the provincial OH&S Division (Appendix C) and by the list of hazards identified by workers and managers during research activity (Appendices A & B).



Occupational Health and Safety Management Systems (OHSMS)

Healthcare organizations in NL have worked on developing programs designed to control hazards. Some are hazard-specific such as those designed to protect those who work at heights or with antineoplastic drugs, while others involve processes designed to recognize, evaluate and control hazards in general.

Incident reporting and investigation programs contain requirements for a thorough investigation of all contributing factors in order to uncover root causes prior to determining the most appropriate control measures to prevent recurrence. While the basic program elements appear to be in place to facilitate this type of investigation, managers and occupational health and safety committees indicate that they rarely have the time, knowledge, training or resources to conduct such a detailed root cause analysis. This may explain why there is a tendency to emphasize changing the behaviour of individual employees following an incident. A common form of “control” involves reminding employees to be more careful or speaking to them about safe work procedures. If such action is initiated following an incomplete investigation that is limited to a review of the immediate cause of the incident, it can be expected to be largely ineffective in preventing recurrence and controlling the root causes.

Many industries have recognized that this type of approach to injury prevention is too limited in scope to effect real change that positively impacts the culture of an organization. There is a growing movement toward a systems approach to occupational health and safety as evidenced by the emergence of standards and programs that are widely adaptable to all industry sectors. Examples include American National Standards Institute *ANSI Z10*, the British Standard *BS 8800*, the International Labour Office *ILO-OHS 2001*, the International Organization for Standardization *ISO 18001*, and the Canadian Standards Association *CSA Z1000*, among others.

An Occupational Health and Safety Management System (OHSMS) provides the framework for a systematic approach to the prevention of occupational injury and disease and sustainable continuous improvement. It involves the deliberate linking and sequencing of processes to create a set of plans, actions and procedures that draws together diverse operational components such as engineering, design, purchasing, quality, risk management, human resources and others to comprehensively control hazards.³⁷

What all reputable OHSM systems have in common is a comprehensive approach to managing occupational health and safety that is performance based, not prescriptive; meaning that it is the outcome that matters more than the means of achieving that outcome. These systems are typically based on a Plan-Do-Check-Act model⁴⁶ that can be summarized as a requirement to:

- Say what you are going to do
- Do what you say
- Evaluate / Prove It

It is the “evaluate/prove it” piece that appears to be weak in many healthcare health and safety programs as they currently exist.

Impact Evaluation

In the healthcare environment, the competing demands of time and resources make it a challenge to evaluate the effectiveness of a new product or work process, especially when a timely decision must be made to mitigate risk based on the precautionary principle. Therefore, it becomes all the more important to study the impact of controls during the various stages of implementation.

Conducting a thorough evaluation provides opportunity to determine if controls or interventions are in fact effective. If they are not, it is often a sign that there may be more detailed analysis required to determine if there are factors that were not identified prior to selecting control measures. If symptoms are treated rather than the root cause, this will likely be identified during the course of an impact evaluation.

It is the lack of attention to this element that appears to have contributed to the incomplete implementation of the Back Injury Prevention Program. This may also serve to explain why the tremendous effort that has gone into health

and safety programming in healthcare has not yet produced more positive outcomes.

Benefits of OHSMS

Many healthcare workplaces are still struggling to achieve legislative compliance as evidenced by the number of directives and recommendations arising out of legislative inspection enforcement activity. This has become a major driving force behind occupational health and safety programming in the healthcare work environment.

Another driving force is the PRIME program of WHSCC. PRIME, which stands for Prevention + Return to Work + Insurance Management for Employers and Employees, puts increased emphasis on workplace health and safety and early and safe return to work while promising financial rewards for employers who follow good prevention and return-to-work practices.⁴⁷

While there is value in any motivational force that propels health and safety programming, the primary motivating factor should be the needs of the industry and the benefits to be realized for the workplace and workers in developing programs and services designed to prevent accidents and injuries. Many industries look to Occupational Health and Safety Management Systems (OHSMS) as a means of strengthening internal safety management practices by channelling resources to areas in which they will have the greatest impact.

Such systems are considered to be a positive alternative to piecemeal, reactive health and safety practices and programs. They are considered to be a necessity in high-hazard industries, but are growing in popularity in industries that operate within a continuous quality improvement framework as well. Many progressive organizations cite the presence of an OHSMS as a critical factor in development of a positive safety culture.

The healthcare sector faces challenges due to shortages of fiscal and human resources as well as time constraints. The demands of OH&S legislation, WHSCC and internal programming all seek the same end result but do not always coincide in terms of priorities and timelines. This sometimes results in competing demands that create significant burden at the operational and administrative level.

Industries and jurisdictions that have successfully promoted a systematic approach to health and safety management have a number of key elements in common, including joint support by employer and union bodies. Another key indicator of success is ensuring that the system is relevant to the industry and specific to the hazards to be managed.

In addition to obvious benefits related to PRIME and legislative compliance there are other advantages to an industry-wide occupational health and safety

management system. For example, the healthcare sector is a huge consumer dealing with thousands of suppliers and numerous contracted services. The system relies on these suppliers and contractors to provide value and quality for scarce healthcare dollars. An OHSMS typically includes a verifiable system for managing product and service safety and quality. This is a well-established commercial imperative designed to ensure that the purchaser of products and services is not exposed to risks created by suppliers and contractors. It goes well beyond the traditional policy approach to contractor and supplier OH&S capability and performance; replacing it with processes with tremendous cost-saving and risk-prevention potential. Improved OH&S performance through the supply chain has been identified as a key factor in successful injury prevention initiatives.

Legislation such as the *Occupational Health & Safety Act and Regulations* is designed around the principles of the internal responsibility system (IRS). This type of legislation lays the groundwork for a systematic approach to health and safety management as it largely sets performance standards and a broad framework for action, but often leaves open the means for achieving those standards. It also gives strong emphasis to health and safety consultative arrangements while providing for back-up enforcement.⁴⁸ Due to the similarities in the framework of provincial OH&S legislation and the approach taken in an OHSMS, legislative compliance is a usual outcome of a successful OHSMS.

This is possible because a reputable OHSMS is designed in adherence to the IRS in the allocation of accountabilities, responsibilities and resources from senior management through to frontline workers to enable decision-making at every level in an organization. A well-functioning OHSMS is fully integrated with the mission, values, and management systems already in place in an industry sector. It is not a stand-alone system and its success is determined by a seamless integration with other aspects of organizational management. While the elements considered to be essential to an effective system are important, it is the linking of separate elements to form an integrated approach that is the defining characteristic of an OHSMS.

Recommendations

1. Healthcare OH&S practitioners should conduct a thorough evaluation of the various Occupational Health and Safety Management System (OHSMS) options with a goal of adopting a system that can be implemented province-wide.
2. A process must be implemented to ensure that all occupational health and safety programs are evaluated at various points of implementation and execution in order to determine if they are achieving desired outcomes.

Self Reliance

Creating a culture of safety requires industry control of health and safety.

The Department of Government Services, OH&S Division, is the provincial government agency that promulgates and enforces occupational health and safety legislation that sets a minimum standard for workplaces in NL. Under the *Occupational Health and Safety Act*, the roles and responsibilities of workplace parties are laid out, as well as the responsibilities and powers of inspectors.⁶ The *Occupational Health and Safety Regulations* address more specific workplace conditions.⁴⁹

Workplace safety legislation has existed in NL since 1978 when the *Occupational Health and Safety Act* was first introduced. Since then, the Act and various supporting regulations have undergone several revisions, with the most recent major overhaul occurring in 2002 at which time a requirement for a Health and Safety Program for employers with greater than ten workers became mandatory.⁴¹ Individual healthcare organizations have been striving to achieve compliance by developing the various elements of a health and safety program as prescribed by this legislation.

One of the roles of the OH&S division in enforcing legislation is carried out primarily by way of investigations and inspections. Investigations can take place following serious workplace accidents or incidents, complaints and work refusals. Enforcement activity tends to focus on poor performers and workplaces where self-reliance is not evident. The mandate of the OH&S Division is to maintain and improve health and safety standards in the workplace through the administration of⁵⁰:

- Occupational Health and Safety Act and Regulations
- Mines Safety of Workers Regulations
- Radiation Health and Safety Act and Regulations
- Asbestos Abatement Regulations and Asbestos Exposure Code Regulations
- OH&S First Aid Regulations
- Workplace Hazardous Materials Information System Regulations
- Other associated Regulations, Codes of Practice and specified standards

It is worthy of note that in the province of NL, mining is the only industry in which there is an industry-specific occupational health and safety regulation. The *OH&S Act and Regulations* govern workplace health and safety in all other industries, including healthcare.

The division is supported by a complement of staff including inspections officers, industrial hygienists, ergonomists, engineers, and radiation specialists to perform various multi-disciplinary activities such as⁵¹:

- Investigating workplace accidents and statistics
- Conducting compliance inspections and detailed audits of workplaces
- Conducting hygiene assessments of various physical, chemical, biological and ergonomic agents in the workplace in order to protect worker health
- Evaluating and inspecting radiation control measures in workplaces
- Enforcing Occupational Health and Safety Legislation

Since workplace health and safety is a provincial responsibility for the majority of industries, including healthcare, legislation differs from province to province. For example, British Columbia⁵² and Saskatchewan⁵³ have regulations that specifically address ergonomics, while Nova Scotia⁵⁴ has the only legislation that cites the role of the Internal Responsibility System in the administration of workplace health and safety.

In terms of healthcare regulations, Ontario is unique among Canadian provinces in that it has healthcare specific regulations that include requirements for immunization, records of inspections of mechanical ventilation systems, sharps injury prevention, respiratory protection, handling of soiled linen and waste, infection control, use of appropriate disinfectants and measures to protect workers from exposure to biological, chemical or physical agents that may be hazardous to reproductive capacity.⁵⁵

In the absence of healthcare specific legislation in NL, workplace parties receiving directives from enforcement officers are often challenged to understand the relevance of a particular regulation or standard in relation to the particular hazard in question. For example, clauses relating to “movement of goods” have been applied to patient handling tasks and the general duty clause is cited routinely, which states: “An employer shall ensure, where it is reasonably practicable, the health, safety and welfare of his or her workers.”⁶

This suggests that many of the hazards that exist in healthcare are not specifically addressed by current legislation, including serious potential health risks created by client handling, needlesticks, exposure to infectious agents and biological hazards, as well as numerous chemicals and hazardous substances.

The OH&S Division has undergone significant restructuring in the past several years and now includes assignment of resources along industry lines. New positions have been created for OH&S officers dedicated to particular industry sectors with a history of high accident and injury rates. Not surprisingly, healthcare is one of those targeted industries. Another significant move within the OH&S Division was the creation of an ergonomist position in recognition of the need to focus on the high percentage of workplace injuries typically associated with inadequate attention to human factors in the work environment.

A review of OH&S Division inspection reports generated from healthcare suggests that many deficiencies exist within the healthcare work environment. Poorly maintained buildings, haphazardly controlled chemical exposures, inadequate fall protection systems and personal protective equipment, high-piled storage, tripping hazards, deficiencies in fire and emergency systems and incomplete safety programs are a few of the issues identified in the hundreds of directives issued by OH&S officers.

Some healthcare workplaces indicate that complying with directives is often achieved at a substantial cost to the system by redirecting financial and human resources and enlisting the services of outside agencies, contractors and consultants. Departments, individuals, and committees responsible for OH&S within healthcare are often challenged to determine the most effective and efficient means of achieving compliance in a manner that satisfies legislative requirements and timelines while minimizing the financial impact on an already overburdened system. Meanwhile, OH&S officers routinely go above and beyond the call of duty to extend time limits and offer advice to organizations struggling to achieve legislative compliance. They also serve as knowledge brokers, directing organizations to information sources that assist them in their occupational health and safety programming efforts or sharing information on leading practices.

As a result of a willingness to work in collaboration with the OH&S Division and acceptance of the role of external regulators, many healthcare workplaces have developed a positive, healthy relationship with officials from the OH&S Division that has proven to be mutually beneficial, while in other workplaces there is evidence of tension between OH&S officers and workplace personnel. This parallels observations by Justice Archie Campbell in *Spring of Fear* as he credits the presence of safety culture in containing the spread of SARS in British Columbia as compared to an apparent lack of safety culture in Ontario hospitals as evidenced by “those in hospital administration and health bureaucracies who resist advice and enforcement on hospital turf by independent worker safety experts and the provincial Ministry of Labour.”³⁵

Justice Campbell’s opinion that attitude toward advice and enforcement is a strong indicator of safety culture is shared among many safety professionals. This warrants an examination of the reasons why tensions sometimes exist between healthcare organizations and the agencies that provide advice and enforcement.

One of the concerns expressed by healthcare managers and OH&S committees is that they feel overwhelmed by the current level of inspection activity that they feel infringes on their ability to set OH&S priorities based on their assessment of workplace needs. This creates added stress on an already overburdened system and sometimes detracts from other priorities, including work being performed to provide a safe and healthy environment not only for

workers, but their clients as well. Research suggests that the reverse is also true - that dedicating time and resources to creating healthy workplaces will benefit patients, residents, and clients, leading to better clinical outcomes.^{56, 57, 58}

Self-reliance is the ability of a workplace and workplace parties to identify and address health and safety issues without the need for outside intervention. The number of directives and recommendations arising from inspection activity indicates that healthcare has not yet reached a point where it can be considered self-reliant in terms of the creation of healthy workplaces. Until such time as this occurs, there must be a concerted effort to reach consensus regarding health and safety priorities in the healthcare sector while allowing all parties to simultaneously fulfill their mandated responsibilities.

Recommendations

1. The OH&S Division of the Department of Government Services, in consultation with the healthcare system, should create healthcare regulations focusing on the control of high-risk hazards unique to the healthcare environment.
2. Healthcare stakeholders must come together to establish a central resource dedicated to assisting the industry to achieve OH&S self-reliance and to provide a collective voice in matters involving legislation and regulatory enforcement.
3. A mechanism must be developed to provide for ongoing consultation between the sector and the OH&S Division.



Internal Responsibility System

Creating a culture of safety requires understanding and application of the principles of the Internal Responsibility System.

Occupational Health and Safety legislation in Canada operates under the philosophy of the Internal Responsibility System (IRS) that places responsibility for safety on all workplace parties, relative to the level of authority exercised within the organization. It is the intent that all parties will work together to create a safe and healthy workplace for the benefit of all.⁴⁰

When the IRS is implemented within an organization, health and safety becomes a part of every employee's job description. Each person takes initiative on health and safety issues and works to solve problems and make improvements on an on-going basis. This is done independently and collaboratively. It is one of the responsibilities of a chief executive officer to ensure that the system of direct responsibility is established, promoted and improved over time. OH&S Committee are key contributors to the IRS as well as departments or individuals for whom workplace health and safety is the focus of their work.

When focus group participants were asked, "*Who is responsible for safety here?*" the overwhelming response was "*Everyone!*" One insightful individual suggested that this is oftentimes interpreted to mean "*Everyone else!*"

Dr. Peter Strahlendorf⁵⁹ is recognized as Canada's leading authority on the IRS. He offers the following list of key components required of a well-functioning internal responsibility system:

- Everyone must have a sincere wish to prevent accidents and illnesses.
- Everyone must accept that accidents and illnesses have causes that can be eliminated or greatly reduced.
- Everyone must accept that risk can be continually reduced, so that the time between accidents and illnesses get longer and longer.
- Everyone must accept that health and safety is an essential part of doing his or her work (health and safety is not an 'extra' - it is part of doing the job).
- Every person must have a clear understanding of what he/she is responsible for, what he/she can do to change matters, and when things must be done.
- Every person must be regularly asked to explain what they have done to ensure health and safety on the job and in the workplace.
- Everyone must have a clear understanding of their own skill, ability and limitations and should have the capacity to carry out their responsibilities.
- Everyone must attempt to avoid conflict when trying to reduce risk.
- As an individual, each person must go beyond just complying with health and safety rules and standards, and strive to improve work processes to reduce risk.

- When an individual cannot reduce risk by him/herself, then they must cooperate with others to go beyond just complying with health and safety rules and standards, and strive to improve work processes to reduce risk.
- Everyone must understand the IRS process, believe in it, and take steps to make it effective at all levels in the organization.
- No one should be fearful of reprisals when using IRS processes.

Recommendation

1. Occupational Health and Safety Committees should undertake a review of the key components of the Internal Responsibility System to assess whether or not it is functioning appropriately within their respective workplaces.

Precautionary Principle

Creating a culture of safety requires application of the precautionary principle.

In 2003, a new disease emerged that made headlines in Canada and around the world as the healthcare system struggled to contain Severe Acute Respiratory Syndrome, better known as SARS. In Canada, 251 people became gravely ill with 43 people dying as a result of the disease.⁶⁰ Three of these individuals were healthcare workers, killed by their work, making SARS not only a public health issue, but a workplace health and safety issue as well.³⁵

In December 2006, Justice Archie Campbell released “*Spring of Fear*”³⁵ the third and final phase of the SARS Inquiry, which, among other things, assessed the outbreak from an occupational health and safety perspective. There is much to be learned from Justice Campbell’s findings, not only for Ontario’s healthcare workplaces, but for this province’s healthcare system as well. Justice Campbell concluded that healthcare organizations in Ontario were poorly prepared for dealing with the SARS outbreak due to lack of application of the Precautionary Principle - “reasonable action to reduce risk need not await scientific certainty.”³⁵ Justice Campbell cites the Precautionary Principle in relation to the issue of respiratory protection for healthcare workers.

In the months immediately following the SARS outbreak, many healthcare organizations in NL amended their respiratory protection programs to include N95 respirators on the list of personal protective equipment provided to protect workers from infectious diseases spread by airborne transmission. Use of these respirators requires the wearer to undergo a fit-test to ensure that there is an adequate seal between the wearer’s face and the respirator. This is one of the requirements as set out in CSA Standard Z94.4-02 *Selection, Care and Use of Respirators*.⁶¹

The selection of N95 respirators for this purpose has generated much controversy, particularly from the infection control community, where concerns have been raised about resource allocation and scientific uncertainty. As a result, some healthcare organizations are in the process of reviewing the requirement for N95 respirators and fit-testing under established respiratory protection programs. Since so much conflicting information has arisen from authorities such as the World Health Organization, Health Canada, and the Center for Disease Control, health authorities find themselves in a precarious position in determining how best to proceed. A number of organizations continue to offer fit-testing to their workers, while others have suspended this activity pending further direction and scientific certainty.

Concerns about exposure to biological hazards factored prominently in focus group discussions; not simply in relation to airborne infectious agents, but in a broader context including needle stick injuries, isolation protocols, adherence to universal precautions, waste management protocols, etc. Many people expressed fear that not enough is being done to mitigate the risks associated with biological hazards that are inherent in the work of healthcare. Concerns such as these were shared by occupational health and safety committees, workers and managers with respect to the control of biological hazards; concerns similar to those identified by Justice Campbell in *Spring of Fear*.

The Precautionary Principle does not apply only to issues related to respiratory protection and airborne infectious agents. It has widespread application to many OH&S issues. *Reasonable action to reduce risk need not await scientific certainty* suggests a responsibility for early adoption of new technologies that can be reasonably expected to positively impact health and safety. Yet while research has identified a number of new and innovative products and services that have been adopted in other jurisdictions with positive results, they have been somewhat slower in gaining acceptance in healthcare organizations in this province. Examples of new technologies and systems include ceiling mounted client lifts, safety engineered sharps and microfibre mops.

When a new technology or program is proposed, there is a cost factor to be considered as well as implications such as impact on staffing and compatibility with other programs and services. The time and resources required to study these implications and to conduct cost benefit analyses is taxing on resources and can delay the decision-making process. On the other hand, evidence abounds about hastily made decisions resulting in costly mistakes due to inadequate research and consultation. Examples include acquisition of unsuitable equipment and substandard services, provision of inappropriate training and building design deficiencies. Depending on the nature of the initiative, the impact of these mistakes can be costly, not only financially, but in risk management terms as well.

The challenge becomes one of striking a healthy balance between facilitating evidence-informed decision-making and application of the precautionary principle, a challenge that stands a greater chance of success by utilizing a collaborative approach within the framework of an occupational health and safety management system.

Recommendations

1. The issue of respiratory protection must be revisited immediately by all healthcare organizations in NL so as to ensure that adequate measures are in place to protect workers from potential exposures to airborne infectious agents. A comprehensive province-wide respiratory protection program should be developed utilizing appropriate expertise in a manner that ensures consistency of application in all workplaces in terms of training, fit-testing, product selection and other vital program elements.
2. A means of ensuring ongoing, meaningful liaison must be established between joint OH&S committees and infection control committees.
3. A comprehensive program must be put in place to identify, evaluate and control biological hazards.
4. The “precautionary principle” should be entrenched in workplace health and safety philosophies throughout the healthcare system to ensure that new work processes, products, services and technologies are researched, evaluated and implemented, without delay, when there is information to suggest that worker health and safety will be improved.



Knowledge

Creating a culture of safety requires evidence-informed decision-making.

In the absence of other forms of reliable data, healthcare has traditionally relied heavily on trailing indicators to determine workplace health and safety priorities and resource allocations. Statistics on the number and frequency of incidents tend to be cited regularly to illustrate the state of affairs regarding safety in the healthcare sector. These measures alone cannot be considered a true determinant of safety performance and should not be used in isolation of other indicators.

Healthcare is not unique in its reliance on trailing indicators. Many industries factor injury statistics into their strategic planning processes. They also

conduct routine risk assessments to ensure that severity is also factored into the health and safety equation, particularly in relation to hazards considered inherent to the nature of their work.

In applying the logic of inherent risk to healthcare, it is first necessary to define what the term means. The Supreme Court of Canada has defined inherent risk as being “incidental to and inseparable from” operational activities.⁶² It is natural for a business to have a degree of inherent risk, which results from the nature of its operational activities and which is intrinsic to the work being done.

Since the business of healthcare is to care for the ill and incapacitated, the risks that are inherent to the industry are those associated with the provision of care. The risks associated with caring for the incapacitated are likely reflected somewhat in incident rates associated with soft tissue injuries. But what about the risks associated with caring for those who are ill, and the associated services that facilitate the provision of care? Healthcare services are available to everyone including those suffering from infectious diseases, prone to violent outbursts, or requiring palliative care. Providing healthcare for the entire population can carry risks that may not be obvious, but can have the potential to be life threatening.

Healthcare workers in Canada have died as a direct result of their work. The SARS outbreak in Ontario resulted in workplace fatalities.³⁵ Acts of violence against healthcare workers have resulted in workplace fatalities.⁶³ Chemical exposures and oxygen deprivation have resulted in workplace fatalities.⁸⁷ Healthcare workers have also suffered life-altering conditions such as hearing loss, amputations, blindness, loss of mobility, and chronic disease.³² In terms of risk assessment, fatalities and life altering injuries are the ultimate measure of severity.

In the healthcare environment, resources are heavily taxed by attempts to provide the programming necessary to control health and safety risks in an effective manner. Efforts to develop effective strategic plans with goals, objectives, and timelines are often impacted by the demands of external agencies, published data, advances in technology, and public pressure. When new data becomes available, it can have a serious impact on health and safety programming priorities. An example of new data becoming available is the release of the 2002 report, *Prevention and Control of Occupational Infections in Healthcare*,⁶⁴ in which Health Canada concluded that using safety-engineered needles or needleless alternatives significantly decreased the number of needle stick injuries in healthcare settings, citing reductions of more than 50% and, in some cases, more than 80% when hollow-bore needles were replaced with safety-engineered alternatives. The same report recognized evidence that early attempts to reduce sharps injury using safety guidelines and training were not successful and suggested that replacing

conventional needles with safety engineered alternatives would be a more effective control strategy.⁵⁷

When a study such as this is released, there are many implications for the workplace. Considerations include knowledge transfer and dissemination, validity, reliability, and relevance and application in the work environment. These and other concerns must be addressed whenever issues related to health and safety are raised, bearing in mind the precautionary principle as well as a requirement for due diligence in determining that all actions undertaken are those considered to be reasonable in the circumstance.

Two issues have been raised in relation to this - the expedition of action and the dissemination of knowledge.

In expediting action, all workplace parties are expected to act in a reasonable manner to ensure that the workplace is safe and healthy. This is influenced by many factors, including the acquisition of knowledge. When new knowledge is gained about health and safety issues, what is considered a reasonable course of action? The answer lies in the basic doctrine of OH&S known as the hierarchy of controls which focuses on the recognition and evaluation of hazards within the source-path-receiver model that demands implementing controls as close to the hazard and as far away from the worker, as possible.

The first consideration in hazard control is to determine if hazards can be controlled at their source (where the problem is created) through applied engineering. The closer the control is to the source of the hazard, the more effective it is likely to be. In an environment in which a culture of safety exists, this will inevitably be the control method of choice with less effective control methods being considered only when engineering controls at the source are not an option, in which case, controls may then be placed along the path between the source of the hazard and the receiver (the worker). This typically involves administrative controls such as policies, guidelines and safe work procedures. Only when all other control options have been exhausted, is it acceptable to implement controls that are applied at the level of the worker.⁶⁵

The release of *Prevention and Control of Occupational Infections in Healthcare* illustrates how the hierarchy of controls is impacted when new information becomes available.

While injuries due to needlesticks have always been a serious concern in healthcare, the absence of engineering controls has meant a reliance on administrative controls such as policies prohibiting recapping of needles and the provision of containers for the collection of contaminated sharps. New information about the effectiveness of safety engineered devices now demands that this issue be revisited to determine if the healthcare system is meeting its due diligence requirements to do everything within reason to mitigate potential hazards associated with exposure to this high risk activity. A provincial

committee has been reviewing this issue and is expected to release a report of its findings in the near future.

This poses a number of questions for the healthcare system. Will adequate evaluation, consultation, education, and change management initiatives be incorporated into any resulting changes? Will action be voluntary or will it require legislation to force compliance? Will government play a lead role in committing the resources required to implement the new technology? The answers to these questions will be yet another determinant of safety culture.

Prevention and Control of Occupational Exposures in Healthcare and *Spring of Fear* are just two examples of the many publications that have significant relevance to health and safety in the healthcare workplace. The prevalence of accidents and injuries in the healthcare environment is a subject that has been extensively studied. Countless reports, inquiries and journal articles have been published detailing issues related to workplace well-being, and providing the science and rationale to support evidence-informed decision making. The question is; are these publications getting to where they need to go to make a difference?

Numerous studies have explored methods by which the physical environment can be enhanced while others abound with details of innovation in health promotion, safe work procedures and quality work-life leading to improved work environments due to timely implementation of products, systems and processes. Ceiling lifts and safety-engineered sharps are examples of engineering control measures that have been widely publicized and that arguably make some healthcare environments much safer places to work.

International examples also exist of areas where research can have significant impact on the well being of worker and client populations. Extensive research has been conducted in Europe and the United States into alternative floor cleaning techniques. Indications are that compared to conventional string mop cleaning methods, microfibre technology can be extremely effective in controlling biological hazards while reducing worker exposure to chemicals and repetitive strain injury. Yet, for all the apparent benefits, uptake of microfibre technology in healthcare workplaces in NL, and indeed in Canada, has been slow. It is encouraging to see that a number of healthcare organizations in this province have recently started to embrace this new cleaning process in their workplaces, but once again, this is an area that can benefit from a comprehensive, systematic, collaborative approach.

In healthcare there is competition for scarce resources. When new information comes along regarding new products or processes, there is usually a substantial cost associated with it. It is therefore vitally important that decision makers are provided with research data in a format that allows them to make informed choices. Ongoing education is also required, since executives cannot be

expected to keep abreast of health and safety issues unless they are provided with pertinent, current information. At times they have been called upon to make decisions on short notice, without adequate knowledge of the subject matter. Education in a crisis is not the answer. Safety professionals and committees must ensure that education is cast in all directions; not only to frontline staff but also to those whose decisions impact all levels of the organization.

Recommendations

1. Central knowledge brokerage services should be established to create an OH&S information repository accessible to the entire healthcare system and to facilitate sharing of leading health and safety practices among healthcare organizations.
2. An initiative should be undertaken immediately to research and develop a systematic approach to introduce ceiling lifting devices, microfibre mops and safety engineered sharps to all healthcare workplaces in the province.

Human Factors

Creating a culture of safety requires a focus on human factors that incorporates all elements of “safety” under one umbrella.

In most industry sectors, risk management refers to processes designed to minimize loss of financial and human resources. In healthcare, risk management follows a more narrow definition centered on legal and financial liability arising from adverse client events.

Since publication of the Canadian Adverse Events Study in 2000, healthcare has elevated quality and risk management to new heights in an effort to create a culture of safety for clients and to rebuild confidence in the healthcare system.

While much good work has been done through organizations such as *Safer Healthcare Now!*, none of the checks and balances arising from patient safety quality/risk management activities are designed to prevent the loss of human resources or to insulate organizations from liabilities associated with failure to comply with OHS legislation. Workplace health and safety departments typically work in isolation from quality/risk management departments, even though there is a growing body of evidence to suggest that the case for a healthy workplace must be positioned as an investment in the long-term health of an organization.⁸⁸

“Siloism” is a term used to denote an organizational structure where programs, services and departments exist independently of one another. The apparent lack of linkages between worker safety and patient safety initiatives is an

example of siloism in the healthcare environment. This is an area that is the subject of a growing body of research, with a focus on the relationship between workplace well-being and service delivery.

The Quality Worklife Quality Healthcare Collaborative (QWQHC) is an organization comprised of 11 national health partners and 45 experts tasked with developing a pan-Canadian action strategy on quality of worklife to improve health system delivery and patient/client outcomes. Working alongside the Canadian Council on Health Services Accreditation (CCHSA), the QWQHC promotes the creation of quality healthcare through quality worklife initiatives.

As one means of accomplishing this goal, CEO's in healthcare organizations across the country are being asked to sign on to the healthy workplace charter which states:

“A fundamental way to better healthcare is through healthier healthcare workplaces; and it is unacceptable to work in, receive care in, govern, manage and fund unhealthy healthcare workplaces.”⁸⁹

The wording of the charter is significant in that it promotes a broadening of responsibility for the creation of healthy healthcare workplaces, linking worker well being with quality of care.

A human factors approach has been touted by some as the means of breaking down the structural barriers that have stood in the way of linking worker-centered safety culture with client-centered safety culture. A human factors approach is based on the philosophy that providing quality healthcare is inexorably linked with creating and maintaining a work environment that supports workers and recognizes their value.

An integrated systems approach under a human factors umbrella that links quality of worklife, operational efficiencies and client outcomes should be viewed as a positive alternative to the program approach that has been the longstanding modus operandi within healthcare.

Recommendations

1. Each Health Authority CEO should commit to signing the Quality Worklife Quality Healthcare Collaborative's Healthy Workplace Charter.
2. There must be improved linkages between the worker safety function and the risk management/quality function under a human factors philosophy that recognizes the correlation between quality of worklife and quality of care.

Training

Creating a culture of safety requires innovation in health and safety training.

When focus group participants were asked what is required to create a culture of safety, the most common answer provided was “training.”

This often led to discussions about various types of training that occurs in relation to healthcare health and safety and the methods by which such training is delivered.

One group that expressed much concern about lack of health and safety training was managers, many of whom are members of site Occupational Health and Safety committees who have received the basic training required of all committee members. This training has provided enough basic information for them to realize the important role they play in workplace safety and the legislated responsibilities that accompany that role, but falls short of providing the detailed knowledge needed to exercise due diligence in terms of their management responsibilities for workplace health and safety. When asked during focus group discussions to describe training they had received to assist them in fulfilling their management responsibilities for health and safety, many were quick to describe training in Early and Safe Return to Work. Others described instruction in the Back Injury Prevention Program. A small number indicated having received training with a focus on legislation, PRIME, due diligence, and management responsibilities. Many offered comments to suggest that training in health and safety was on par with other aspects of management training. Overall, they appeared to be more knowledgeable about WHSCC programs and policies than about OH&S legislation.

Since workplace safety isn't an ingrained management responsibility it requires deliberate training and explanation. If persons who direct the work of others are to be held accountable for fulfilling their legal and organizational responsibilities for workplace health and safety, they must be provided with the information to enable them to fulfill those responsibilities.

Another issue that garnered much discussion among workers and managers was training in safe work procedures. Many expressed the opinion that orientation training does not provide adequate attention to workplace hazards and listed co-workers as the primary source of training in safe work procedures. Others expressed dismay that they were unable to apply training in safe work procedures they had received during post secondary education, suggesting a possible disconnect between training institutions and the healthcare workplace.

Training in relation to advances in technology was also a hot topic of discussion. Many workers expressed concern that their work is now dependent on technology that did not exist when they received formal training and this has caused them to experience considerable stress as they struggle to adapt, without adequate training and support, in a physical environment that is often unsuited to new technology. This speaks of a shortcoming in recognizing the importance of human factors in instituting changes to work processes. According to research, workers who must adapt to new technology without adequate training and information are prone to develop symptoms of soft tissue injuries.^{21, 66}

Once soft tissue injuries have developed, there is reliance on rehabilitation professionals, usually occupational therapists, to assess workstations and provide individual workers with information and training on safe work procedures in relation to work practice hazards. Depending on the background and ergonomics expertise of the rehabilitation professional, as well as the culture of the workplace, this assessment and training may be limited to the physical work or it may focus on the much broader human factors that incorporate psychosocial, cognitive and cultural elements. In either case, this approach is reactive and may not be the best use of scarce ergonomics expertise.

Ergonomics, or human factors, covers a breadth of knowledge and practice that is seldom truly recognized or utilized in this province's healthcare structure. As defined by the International Ergonomics Association, an ergonomist "contributes to the design and evaluation of tasks, jobs, products, environments and systems in order to make them compatible with the needs, abilities and limitations of people."⁶⁷ This highlights the need for applying ergonomics in the earliest stages possible in projects where there are opportunities to improve or optimize the healthy and productive fit between a worker and the work environment. If properly utilized and integrated into a workplace, ergonomics can help to prevent the need for workstation reviews as reactive assessments.

Another topic that received much attention was computer training. It is fair to say that the majority of healthcare workers are now required to perform data entry using a computer keyboard at some point during their working day, yet with the exception of clerical staff, most healthcare workers, particularly those who have been in the workforce for over a decade, have never received any formal training in keyboarding. Standards have been developed to protect workers from soft tissue injuries arising from computer usage by providing guidelines for the positioning of keyboards, monitors, and other hardware. These standards are developed assuming that computer users will maintain good body positioning that includes good sitting postures.⁶⁸ This is quite possible for persons with the ability to touch-type who look straight ahead at a monitor allowing the neck to remain in a neutral position during the

keyboarding process. However, it is a challenge for those lacking in touch-typing skills to do so, due to the repetitive neck flexion and extension created by constantly looking downward at the keyboard and forward at a monitor. This detracts somewhat from the benefits provided by proper positioning of equipment and could be one of the contributing factors to neck and shoulder pain among computer users.

Therefore, this repeated call from focus group participants should come as no surprise:

“Teach me to type!”

Another area where training appears to be lacking is in relation to chemical hazards. A review of workplace inspection data appears to corroborate concerns expressed by workers about a lack of instruction and training in the safe use, handling and storage of hazardous substances in many healthcare workplaces.

WHMIS legislation is jointly administered between provincial and federal governments. It requires written procedures and labelling requirements for biological, chemical, and physical agents as well as instruction in the safe use, handling, and storage of hazardous substances. Many workers report having received generic training in WHMIS labelling and reporting requirements but expressed concern about a lack of training in how to safely use, handle, store, and dispose of *specific* chemicals and other hazardous substances used in their work.

Training appears to be an issue as well in relation to respiratory protection. Although the applicable CSA standard clearly states that respiratory protective devices cannot be worn unless the wearer has been trained in the safe use of such devices, many workers reported having been fit-tested or provided with various forms of respiratory protection with no accompanying training.

In any large operation, it can be a challenge to ensure that training is delivered in a way that meets the needs of a diverse worker population. Research reveals that many organizations have experienced success with technology that provides new opportunities for training delivery, including the use of e-learning, videoconferencing, web-conferencing, hazard simulation, etc. While this can be useful for many aspects of healthcare education, it can be particularly beneficial for health and safety since many healthcare workplaces do not have sufficient in-house health and safety resources to provide training and it is a challenge to find private training consultants with expertise in healthcare health and safety. Since training is such a major component of occupational health and safety, the healthcare system must ensure that systems are in place to provide training in a way that best meets the needs of the sector.

Recommendations

1. Ergonomics expertise should be utilized to provide training and information to a broader worker population base including key groups such as facilities maintenance, purchasing departments and biomedical personnel.
2. Managers at all levels must be provided with detailed information regarding their legislated and organizational responsibilities for workplace health and safety.
3. A needs assessment should be conducted in each workplace to determine training requirements in relation to specific hazards, including safe work procedures and the management of hazardous substances.
4. E-learning and other new technologies should be utilized for health and safety training when it is feasible and practical to do so.
5. Managers and workers who routinely use computers in the performance of their work should be provided with instruction in basic keyboarding techniques.

Leadership

Creating a culture of safety requires strong leadership and management commitment that is visible and believable.

According to the principles of the Internal Responsibility System (IRS), accountability for health and safety starts with those at the top of an organization who must ensure that all persons are provided with the tools and information necessary to fulfill their occupational health and safety responsibilities. This is important from a legal perspective, but unto itself, will not bring about the type of transformational change required to create a culture of safety.

Leaders influence cultural change in many ways such as providing resources to establish programs and through memos and presentations to staff in large forums. However, they also influence people on a one-to-one basis in the conversations that take place throughout the day.

Creation of a safety culture occurs when management is truly committed to health and safety programming and expresses this to employees through daily interactions, which emphasizes the organization's commitment to workplace safety and sends cues about the sincerity of these efforts. Dialogue is used to develop ideas, make decisions, communicate support, acknowledge good work and assign accountability. It is a powerful tool in transforming a culture of blame to a culture of safety.

If a leader is truly committed to changing workplace culture, he or she must talk about health and safety with those who will influence cultural change. Having two critical conversations a day will translate to 500 a year, which will likely have a greater impact on cultural change than any policy or program. If all managers engage in this level of conversation about workplace health and safety, cultural change will be imminent.⁶⁹

Dialogue can occur in a variety of forms. It can be unplanned and informal, occurring anytime and anywhere managers and workers come together, or it can be planned and formal by way of regular staff meetings. In order to be truly effective in bringing about cultural change, both forms of dialogue must happen.

In order to ensure that formal dialogue takes place, monthly staff meetings should be held and issues related to “safety culture” should be standing agenda items. It is vital, however, that such meetings address issues relating not only to the physical environment, but must encourage discussion of workload, conflict, staffing, work organization, social events, health promotion, safe work procedures, and the status of resolving identified hazards.

When engaging in informal dialogue, managers have a choice between relaying information and telling stories. Research reveals that relaying information rarely generates the same level of meaningful return as does telling stories. Story telling tends to spark meaningful two-way discussion. Stories can be a powerful tool for influencing others and bringing about cultural change because they can make a point in a way that no other form of communication can. They serve to increase trust and eradicate blame because they tend to provide insights into actual events while highlighting the challenges and successes that often accompany them.⁷⁰

Recommendations

1. Managers must be provided with the tools, education, support and resources necessary to effectively perform their legislated health and safety responsibilities.
2. Managers at all levels in every organization should engage in regular meaningful dialogue about health and safety by informal and formal means, including regular monthly staff meetings and informal conversations.
3. Monthly staff meetings should be mandatory in every department or functional area, with standing agenda items to be determined in consultation with departmental staff using the following as a minimum standard:
 - a. Health and safety hazards
 - b. Hazard control communication
 - c. Staffing, scheduling & workloads
 - d. Safe work procedures
4. OH&S Department personnel and/or OH&S committee members must support managers by attending staff meetings upon invitation and by providing technical advice and consultation as requested.

Community

Creating a culture of safety requires recognition of the unique needs of the community sector.

In traditional workplaces, the environment is controlled by the employer and regulated by OH&S legislation. When the work environment is a client's home, the employer is challenged to provide the same health and safety standards but ensuring a safe work environment is still a legal responsibility. Collaboration involving employers, workers, clients and regulating agencies is integral to developing an effective health and safety program for this sector since each home setting is unique.

During focus group discussions, workers in the community sector identified various hazards, including:

- Unsafe physical/environmental conditions (noise, stairs, ventilation, physical isolation, cramped space, unsanitary conditions, odours).
- Exposure to biological and chemical hazards (animals, rodents, drug paraphernalia, scented products, mould, garbage, unlabelled chemicals).
- Potential violence from clients and family members.
- Travel hazards in inclement weather and unsafe, slippery roads.
- Working alone.
- Lack of reliable means of communication.
- Lack of client handling equipment.
- Heavy caseloads leading to stress and burnout.

Community sector workers also expressed concern with the stress of trying to comply with facility-based policies that some feel have little relevance in their environment.

Research indicates that hazards in the community environment are complex and among the most difficult to control, yet they pose some of the most serious risks identified in any health sector, particularly in relation to working alone, which exposes workers to increased risk of violence and aggression from clients, families, and others.^{55, 71, 72}

Recommendations

1. A hazard recognition, evaluation and control program, specific to the community environment, should be established without delay.
2. Current OH&S policies and procedures should be reviewed to determine if they are appropriate for the community environment.
3. Employees who work in remote locations must be provided with adequate means of communicating in emergency situations.

Communications and Collaboration

Creating a culture of safety requires improved communications and collaboration.

Lack of communication surrounding occupational health and safety issues and accomplishments was noted as a concern in focus group discussions, survey data and consultation with OH&S committees and practitioners. It is widely recognized that clear channels of communication are a key component in the creation of a safety culture.⁷³

One of the largest disconnects in communication appears to surround consultation and decision-making with over 55% of survey respondents reporting inadequate involvement in that process. This was also reflected in comments from the survey and focus groups.

“It would be nice to have more opportunity to speak with management regarding work related issues. It has become a very impersonal and cold working environment.”

“We mean very little to upper management as they always make their decisions without asking nursing staff - however I think our immediate managers are much more influenced by our thoughts and ideas.”

“Management and employees do not work together and at my site if anything is suggested it never gets carried out.”

As mandated by the HWI logic model, a number of communications activities were undertaken during the course of this project, including creation of a newsletter, *Safety Shift*, for the purpose of informing the healthcare system about project activities and events. This newsletter soon evolved into an information source about healthcare health and safety news in response to requests for information from workers and managers throughout the system. *Safety Shift* led to added opportunities for consultation and collaboration, in particular when an article on ceiling lifts caught the attention of the Department of Health and Community Services and generated a meeting on the topic with key officials.

In addition to a newsletter, a need for a project website was identified. www.safetyculture.ca was launched in May 2006, and has attracted a steadily increasing number of visitors each month.

The website offers visitors information on project activities, news and events, as well as a variety of interesting occupational health and safety links and facts. The website also houses three online forums. A public Community Forum provided as a tool to facilitate increased collaboration and communication

among healthcare workers to encourage a sharing of concerns, ideas and leading practices and two private forums developed for special interest groups within the healthcare system - Ergonomists and OH&S Practitioners. The Ergonomists' Forum is used routinely for collaboration on common issues between meetings of the Ergonomics sub-committee. It is equipped with a document-sharing feature that provides members with the ability to post policies, forms, position papers, studies, etc. It has been used extensively and its popularity brought about the development of an identical tool for OH&S Practitioners, dubbed the Members' Only Forum.

Another major project initiative intended to foster collaboration and communication was the Healthcare Workplace Safety Conference, the first event of its kind in NL, which provided opportunity for healthcare workers from across the province to interact with their peers, while learning together about the latest trends in occupational health and safety from a local, national and international perspective. This event attracted approximately 140 delegates, presenters and exhibitors who gathered for three days of information sharing. It also served as a vehicle to present an overview of HWI project outcomes.

The conference concluded with a full day workshop entitled *Including Ergonomics in the Design of Healthcare Facilities*, sponsored by the Association of Canadian Ergonomists and a half-day workshop entitled *Ceiling Lifts: The Voice of Experience*, sponsored by the Healthy Workplace Initiative. Both workshops attracted participants from the healthcare system as well as union representatives, engineering and design consultants from the private sector.

Ceiling-mounted Client Lifting Devices

In the early 1990's, The Back Injury Prevention Program introduced mechanical lifting devices as a substitute for manual lifting of patients and residents in acute care and long-term care settings. Various designs of floor model lifts have been provided since then to assist caregivers with a means of providing personal care in a way that reduces the potential for soft tissue injuries that accompanies this high-risk activity.

However, the early success attributed to the use of mechanical lifting devices was short-lived. According to information gathered during project research, this can be attributed to many factors, including difficulty in manoeuvring mechanical floor lifts into small cluttered rooms, the time and distance involved in retrieving lifts from storage or other areas of use, wait times due to sharing of lifts among rooms and units and downtime due to mechanical failure and inadequate maintenance.

In recognition of the limitations associated with the use of mechanical floor lifts, some healthcare organizations throughout Canada and around the world have chosen to replace or supplement mechanical floor lifts with ceiling mounted devices.

Ceiling lifts consist of a tracking system attached through the ceiling and fastened to the joists, beams or other overhead support structure of a facility. A motor is propelled manually or mechanically along a track to which an electrically powered elevating device is attached to a sling used for lifting, transferring or repositioning a client with limited mobility.

Interior Health in British Columbia is one of many healthcare organizations that have invested significant resources in this technology in recognition of the need to control hazards associated with client handling procedures. Interior Health undertook a program to provide 100% ceiling lift coverage in extended care facilities after evaluating a number of pilot projects. Due to the positive results realized in this sector, efforts are now underway to establish similar initiatives in the acute care and home care sectors.

The positive experience reported by Interior Health is similar to that of other locations including Fraser Health (also in B.C.) as well as other Canadian, American, British, European and Australian healthcare workplaces that utilize ceiling lifts to make healthcare workplaces safer for caregivers.

A small number of ceiling lifts have been installed in facilities in NL. Dialogue continues between the Health Authorities and the Department of Health and Community Services as to the level of funding to be provided for ceiling lifts in new facilities currently in the planning and design stages. As the province and the Health Authorities move forward with pilot projects, product evaluations and retrofit of existing facilities, it appears that somewhat of a piecemeal approach is unfolding yet again. In order to avoid the mistakes of the past and to benefit from lessons learned from other jurisdictions, it is important to put safeguards in place to ensure that this is done systematically in a manner that promotes worker, client and family engagement, organizational uptake and continuous quality improvement leading to long-term viability and sustainability throughout the sector. Anything less than this type of comprehensive, collaborative approach cannot be expected to produce the type of results necessary to create healthy healthcare workplaces.

Recommendations

1. Healthcare partners should determine a means of maintaining OH&S communications initiatives such as the newsletter *Safety Shift* and the project website, www.safetyculture.ca.
2. A review should be undertaken of methods by which inter-professional and multi-stakeholder health and safety communication and collaboration can be enhanced throughout healthcare organizations.
3. Provincial working groups should be established to address workplace health and safety issues of common concern throughout the entire system under the coordination of a central resource.

4. The Ergonomics working group should be supported and encouraged to continue developing HWI initiatives and objectives.



Violence

Creating a Culture of Safety requires increased attention to issues related to workplace violence and conflict.

Anecdotal evidence from focus groups suggests that conflict and discord is commonplace throughout many healthcare workplaces and may not always be addressed adequately or in a timely manner, sometimes intensifying to the point where serious risks to health and safety are created. Workers cited examples of conflict among individuals, disciplines, departments and groups including disturbing stories of bullying, tension, mockery, insults, racial intolerance, emotional and verbal abuse, harassment and physical assault.

This was also noted in an independent best practice review commissioned in the healthcare system in 2005, which stated, *“Conflict appears to be a daily experience in the health environment, yet it appears that it is rarely acknowledged and rarely dealt with in an effective manner, if at all.”*⁷⁴

Some of the reasons cited by focus group participants as contributing to the creation of conflict are:

- Lack of manager presence.
- Poor communication leading to misunderstanding and misinformation.
- Accommodation of injured employees resulting in perceptions of uneven work distribution for other staff.

- Frustration due to staff shortages.
- Realignment of job functions among various disciplines and departments.

The existence of conflict is not limited to the internal environment - many workers reported being subject to acts of aggression and violence or threats of violence involving clients, families and visitors.

“We have a relative who visits routinely who is disruptive and threatening. When we report it we are told we are not handling the situation well and we are probably responsible for inciting her to make threats of violence so we should change the way we deal with this individual or leave. Some staff left but not all of us have that option so we work in fear.”

“At times I feel unsafe in relation to security issues. We have no trained security guards employed at our hospital. This causes increased stress when dealing with agitated or aggressive patients keeping in mind the high substance abuse and related crime in this town.”

“I deal with criminals and psychiatrics who may commit suicide and try to take me with them... This is very dangerous.”

Recent publications by Statistics Canada and the CBC indicate that this is a problem that is widespread throughout the entire country.^{75, 76} The Workers’ Compensation Board of Nova Scotia reported that 358 registered nurses filed claims stemming from violence between 1994 and 2004, compared to 96 police officers who did so in the same time period.⁷⁶ The same study revealed that healthcare workers in NL file nine times as many WHSCC claims for violence related incidents as those in other industry sectors.

In Canada, there are currently four provinces with OH&S regulatory requirements covering workplace violence - Alberta, British Columbia, Prince Edward Island and Saskatchewan. Quebec has a regulation banning not only violence but also psychological harassment in the workplace. While OH&S legislation of the other provinces doesn't specifically address workplace violence, there is a general duty clause requiring employers to take all reasonable precautions to protect workers' health and safety. This includes hazards related to workplace violence.⁷⁷

Acts of violence and aggression conducted by individuals who cannot be held responsible for their actions due to cognitive impairment or similar conditions are common in healthcare. This creates significant challenges due to the ethical dilemma surrounding the balance of rights and responsibilities in the caregiver/client relationship. However, this is just one aspect of the violence that exists within healthcare. Not all individuals conducting or threatening acts of violence suffer from cognitive impairment. In a forum conducted on

February 27, 2007 as a joint venture between the Association of Registered Nurses of NL (ARNNL) and the NL Association of Social Workers (NLASW), many issues were raised regarding violence in the healthcare environment that were similar in content to those arising out of national and local research:

- Acts of rage in response to wait times and delays in service.
- Drug-induced aggression.
- Domestic violence in the home and community environment.
- Lack of information about client history re violent tendencies.

Recommendations

1. Workplace conflict resolution mechanisms should be evaluated and new systems established in workplaces where none currently exist.
2. Managers and workers should be educated in conflict management/conflict resolution.
3. Hazard assessments should be conducted to determine where and in what form risks of violence exist within the physical and psychosocial work environment.
4. Violence prevention programming should be developed and implemented that addresses identified risk factors including security services, working alone, self-defence training, conflict resolution mechanisms, non-violent crisis intervention, emergency response, communications and engineering controls.
5. Unions and employers must work together to determine bonafide occupational requirements applicable to security personnel to ensure that they are capable of providing adequate services in dealing with acts of violence in the workplace.
6. The unique needs of the community sector should be assessed in relation to protection from violence, aggression, and conflict in recognition of the increased risk created by working alone in an uncontrolled environment.

Change

Creating a culture of safety requires the application of change management protocols.

Healthcare personnel have difficulty changing long-standing practices. This observation comes from a number of studies including several conducted in the years following implementation of universal precautions, when observed compliance with even the most basic of recommended practices, such as hand-washing, fell seriously short of expectations.

When change is introduced in a system as complex as healthcare, success or failure will depend on how well the change is managed. Research indicates that this is equally important whether the change is transformational, such as a change in culture, or if it is in relation to a specific activity such as introduction of microfibre mops or establishing a requirement for regular staff meetings.⁷⁸

It is well known that any type of change can cause disruption, fear, resentment, resistance and numerous other emotions that can be unhealthy for workers and have negative repercussions for the culture of the workplace. They also tell us that change, when managed strategically, with due consideration for human factors, can result in positive consequences.⁷⁹

Since it has been documented that over 87% of change initiatives fail on implementation, attention to change management protocols is of vital importance.⁸⁰ This is because most people have some apprehension about change. *"If you don't deal with the people side of change,"* says Dr. Mark Tager, *"your people get sick and then they are not on the job. They also become internally distracted and are more prone to accidents. They are also more likely to file grievances and they are less productive."*⁸¹

Organizational restructuring can contribute significantly to the psychosocial stressors affecting workers. Since the provincial healthcare system is well into the second round of major restructuring, there should be a concerted effort to review the outcomes from similar events in the 1990s.

In May 1997, government held a Provincial Health Forum, chaired by Roger Grimes, Minister of Health at the time. The public forum was organized primarily to respond to changes that restructuring had created for the newly established boards, clients and frontline workers. While no publications came out of the forum, one of the issues identified was workload stress on frontline workers.

In order to minimize the stress that accompanies a change of this magnitude, the healthcare system should take steps to ensure that change management protocols are developed and utilized.

Likewise, when addressing something as transformational as cultural change, it is necessary to research the critical success factors required to bring about this type of change.

This is a subject that has been studied by many researchers, among them Harvard professor Dr. John Kotter, regarded by many as the most respected writer on change. Kotter purports that successful change requires belief in two basic truths:⁷⁹

- Change is a multi-step process that overcomes inertia through the "power and motivation" it generates.
- Change is "driven by high-quality leadership, not just excellent management."

Kotter makes a crucial distinction between leadership and management: Leaders set direction, align people, motivate and inspire; managers plan, budget, organize, staff, control and problem solve. According to Kotter, what's

needed is not change management but change leadership that drives an eight-step process for achieving successful change. The steps are:⁷⁹

1. Create a sense of urgency.
2. Create a guiding coalition.
3. Develop a vision and strategy.
4. Communicate the change vision.
5. Empower broad-based action.
6. Generate short-term wins.
7. Consolidate gains and produce more change.
8. Anchor new approaches to the culture.

Create a sense of urgency

According to Kotter, the biggest mistake people make when trying to change organizations is to plunge ahead without establishing a high enough sense of urgency in managers and employees. This error is fatal because transformations always fail to achieve their objectives when complacency levels are high.⁷⁹ Managers overestimate how much they can force big organizations to change and underestimate how hard it is to drive people out of their comfort zones. They don't recognize how their own actions can inadvertently reinforce the status quo.

Create a guiding coalition

Major change is often said to be impossible unless the leader of an organization is an active supporter. But it needs to go deeper into the organization, involving a large group of key people with a commitment to drive the change - a group with formal titles, information and expertise, reputations and established relationships. Efforts that lack a sufficiently powerful guiding coalition can make apparent progress for a while but sooner or later countervailing forces will undermine their initiative.

Develop a vision and strategy

Urgency and a strong guiding team are necessary but insufficient conditions for major change. Of the remaining elements always found in successful transformations, none is more important than a sensible vision that can help to direct, align, and inspire efforts by large groups of people. Kotter warns: *"In many failed transformation efforts, plans and programs try to play the role of vision. Whenever you cannot describe the vision driving a change initiative in five minutes or less and get a reaction that signifies both understanding and interest, you are in for trouble."*⁷⁹

Communicate the change vision

People will neither make sacrifices nor change behaviour - even if they are unhappy with the status quo - unless they think the benefits of change are attractive and unless they believe a transformation is possible. That requires credible communication, to capture employees' hearts and minds. According to Kotter, *"communication comes in both words and deeds. The latter is*

generally the most powerful form. Nothing undermines change more than behaviour by important individuals that is inconsistent with the verbal communication. And yet this happens all the time.”⁷⁹

Empower broad-based action

New initiatives fail far too often when employees - even though they embrace the new vision - feel disempowered by huge obstacles in their paths including such factors as organizational structure or lack of meaningful communication.

Generate short-term wins

Complex efforts towards change can lose momentum if there are no short-term goals to meet or celebrate. Kotter says: *“You can’t hope for short-term wins. That’s too passive. You have to create them. In a successful transformation, managers actively look for ways to obtain clear performance improvements, establish goals in the yearly planning system, achieve these objectives, and reward the people involved.”⁷⁹*

Consolidate gains and produce more change.

After a few years of hard work, people can be tempted to declare victory in a change effort after the first major performance improvement. Celebrating the win is fine but until change sinks deeply into the culture, transformational change will not be realized. When dealing with a large organization or an entire industry sector such change can take three to ten years.

Anchor new approaches to the culture

Cultural change only solidifies when it becomes “the way we do things around here.” It has to seep into the very bloodstream of the organization. Until the new way of doing things are rooted in social norms and shared values, they can degrade as soon as the pressure from the transformative effort is lifted. This requires a conscious effort to show people how specific behaviours and attitudes have made a difference and by ensuring that management really does personify the new approach.

In order to create a culture of safety, these change management factors must be applied in every undertaking related to the creation of healthy healthcare workplaces.

Recommendations

1. Senior leadership teams must spearhead the changes required to create a culture of safety.
2. Healthcare managers must be educated in how to apply the factors necessary to cultivate change successfully.

Resources

Creating a culture of safety requires adequate allocation of resources.

Healthcare is the largest single drain on the public purse, accounting for approximately one third of all government spending.⁸² Government is challenged to provide adequate funding for the system and health authorities are challenged to make the most effective and efficient use of resources.

With pressures faced by a cash-strapped healthcare system, the challenges of resource allocation are many. Existing system resources will need to be reallocated or additional resources provided in order to create the capacity to both enable and sustain the creation of a culture of safety.

To effectively create such capacity within the healthcare system, both innovation and ingenuity must be applied, along with a multi-faceted systems approach that recognizes that dollars spent today on creating a culture of safety will not likely demonstrate an immediate impact. Return on investment on occupational health and safety initiatives typically takes years to see tangible results but can provide a huge return on investment in the long term.

Without adequate investment of human and financial resources, the cultural transformation required to create healthy healthcare workplaces will not be realized.

The issue of resource allocation was one that came up in various venues during the course of the HWI consultation process. Many individuals expressed the opinion that recommendations arising out of this project will be ineffectual unless the decision makers can be convinced to devote sufficient resources to implementing meaningful solutions.

Funding of the initiatives required to create a culture of safety is complicated by a two-tiered structure. While the internal administration of each health authority is provided with a certain level of autonomy over budgetary spending, the provincial government provides funding and approves annual operating and capital budgets. This leads to a situation whereby the people making decisions at the operation level do not necessarily have full control over resource allocations, particularly in situations requiring multi-year investments or major capital expenditures.

A healthcare best practice review conducted in 2005^{75,83} indicates that historically only 10% to 15% of capital works projects submitted to the Department of Health and Community Services are approved, noting a need for replacement of outdated equipment such as manual beds.⁷⁵

During the course of HWI activities, the issue of resource allocation for funding of ceiling lifts in new facilities was addressed. Consultation with

representatives from government and the health authorities revealed that there appeared to be somewhat of a disconnect among those involved in such decision making with various parties operating from different sets of research data. There is obviously much to be gained from improved collaboration based on an agreed-upon criteria arising from valid and verifiable data sets.

Accidents, illness, and injuries are very costly to healthcare. In 2003, absences for these reasons amounted to the equivalent of 1150 full time positions. As well, provincial healthcare employers pay WHSCC assessment rates that are higher than any other Canadian jurisdiction. The PRIME program offers monetary incentives that amount to millions of dollars in potential rebates for the healthcare system. A significant investment will be required to ensure that the required elements are in place to qualify for these rebates and if they are realized, what will become of them? Will this money be reinvested back into general operating revenues or dedicated to the creation of healthy healthcare workplaces?

A framework is needed to assist in targeting priorities and investments in developing a systematic approach to accident and illness prevention through an emphasis on meaningful change that is sustainable well into the future. The days of a piecemeal approach to health and safety must end if the healthcare system is to get serious about creating a culture of safety.

This can best be accomplished through a collaborative approach involving the health authorities, government and other stakeholder groups in a joint initiative designed to support, co-ordinate and enhance workplace health and safety for the benefit of the entire province.

Recommendations

1. Health Authorities should enact policies ensuring that any money refunded through PRIME rebates will be reinvested directly into activities that have a direct impact on the creation of healthy workplaces.
2. The Department of Health and Community Services should create a new position for an Ergonomist to be consulted in matters involving capital expenditures, building design, workload measurement, etc.
3. The provincial government should make long-term, multi-year funding investments in the healthcare system to provide for the design and implementation of infrastructure improvements including building upgrades and provisions for engineered injury prevention systems including:
 - a. Increasing the size of patient/resident rooms and bathrooms to provide a safe work environment for individuals engaged in client care.
 - b. Installing ceiling track client lift systems in all newly constructed or renovated facilities.
 - c. Installing or upgrading heating, ventilation and air conditioning systems to provide for a healthy and comfortable thermal environment.
 - d. Replacing manual crank beds with electric beds.

- e. Replacing sharps instruments with safety engineered devices.
 - f. Introducing microfibre floor cleaning technology.
 - g. Providing adequate storage space.
 - h. Installing guardrails, roof anchors and other forms of engineered fall protection systems as identified in working-at-heights hazard assessments.
 - i. Replacing worn, slippery and problem flooring.
 - j. Upgrading or replacing biological safety cabinets.
 - k. Installing communication devices, alarms, barriers, enclosures, dual-swing doors and other forms of engineered violence-prevention systems as identified in violence-prevention hazard assessments.
 - l. Upgrading and improving waste disposal systems
 - m. Providing human resources information systems with the capacity to track health and safety data, including workload measurement systems that ensure the provision of safe staffing levels
 - n. Developing mechanisms to ensure allocation of sufficient capital and operational funding to ensure that buildings and equipment can be adequately maintained to ensure provision of a safe and healthy work environment.
4. Health Authorities and their partners as represented on the HWI steering committee should commit to building on the momentum created by this project by establishing and supporting a central resource dedicated to creating a healthcare system that truly embodies a *culture of safety*.



Conclusion

Despite the best efforts of committed individuals and organizations and the dedication of significant resources, there is evidence to suggest that a culture of safety has so far eluded the healthcare system in NL.

The Healthy Workplace Initiative - *Creating a Culture of Safety* has spent eighteen months seeking answers to why this is so.

This document has addressed some of those answers as identified through analysis of data collected from people closest to the issue. Alarming injury statistics provided the springboard that launched this initiative. The stories, perceptions and opinions of stakeholders supplied the fuel that motivated us to think big and then think bigger. The information highway propelled us into a world of academics and pioneers, thinkers and doers, and led us to a place where there is excitement about what lies beyond the horizon.

As we approach that horizon, there are many decisions to be made about what it will take to get to the other side. The side that perceives workplace health and safety as a core value of all who work in, receive care in, govern, manage and fund healthcare workplaces. These are the people in the driver's seat who will move this vehicle forward, using the messages in this report as a roadmap to guide them toward the culture of safety that lies just beyond the horizon in the healthcare workplaces of Newfoundland and Labrador.

“Workplace well-being is about many things: it is about people having meaningful and challenging work to do with an opportunity to apply their skills and knowledge; it is about working effectively with colleagues and managers; it is about a work environment that is safe and healthy, that is respectful of individuals and their different circumstances, including the need for work-life balance, and where people have the tools they need to get the job done; it is about being fairly compensated, both in terms of salary and benefits; it is about having learning opportunities and possibilities to achieve personal career aspirations. Workplace well-being is about all of this and more. But it comes down to one simple fact: when employees are satisfied with their work environment and working conditions, they can make their best contributions and provide high quality services and they can make their best contributions and provide high quality services and programs to Canadians. Report of the Committee of Senior Officials (COSO) Sub-Committee on Workplace Well-being, September 2000.

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Healthy Workplace Initiative
Focus Group Summary

Focus group discussions were held at sites throughout the province during the course of HWI project research. Separate sessions were held for managers and frontline workers to encourage open and honest discussion on a number of topics.

Each of the questions presented to participants appears below, along with a sampling of the thousands of responses received.

Question 1.

Describe hazards that exist in your workplace. What has been done to control them?

Ergonomics:

- Constantly moving patients, beds, stretchers, and equipment in and out of rooms.
- Not enough electric beds, wheelchairs and mechanical lifts.
- Always in a rush means doing things the quickest way, not the safest way.
- Pressure from co-workers and managers to speed up the work.
- Not enough variety in work – 12 hours repeating same movements over and over.
- Large carts make it impossible to see over or around them.
- Stress created by pressure to get the work done as fast as possible.
- Families dictate how care is provided, even if it puts staff in danger.
- Poorly designed workstations in relation to work flow.
- Dragging heavy equipment in and out of cars, over stairs and into clients' homes.
- Working in a closet converted into an office.
- Bathtubs are a nightmare. No easy way to give a bath.
- It's too hot and stuffy to be comfortable or healthy.
- New equipment and new environment make the work harder.
- It's impossible to get them to change their old work habits.
- Shelving and storage not functional – too high, not enough, not easily accessible.
- People don't get along well enough to help each other out.
- Electric beds are constantly being moved; they are heavier than manual beds.
- One bed per room is against the wall; can't use mechanical lifts.
- Two people needed to move large carts but cannot get permission to do so.
- Uneven floor surfaces with cracks, holes and high thresholds.
- Not enough staff to work in teams, no encouragement to do so.

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- Swinging a heavy mop and pushing a cleaning cart for an entire shift.
 - Half the people working with you are injured and increase the chance of you being injured because you are picking up the slack.
 - Population is getting heavier.
 - Changes in pain management protocols make patients unpredictable.
 - No time to encourage residents' independence with such things as feeding themselves; just poke it in their mouths and move on; soon they get even more dependent and workloads increase.
 - Cramped cluttered space.
 - Managers are too busy to identify or correct hazards.
 - Transporting patients, especially ICU (moving bed, two IV poles, and oxygen).
 - Beds have no heads to use when moving.
 - Workplace is constantly changing and there is no support to help staff adapt.
 - Nothing is fixed until someone is hurt.
 - Elevators are too small and wheels get caught in floor gap.
 - Need lighter oxygen tanks.
 - New stretchers are causing shoulder injuries.
 - Bankers boxes full of files stacked six to eight feet high.
 - Desk in nursing station is too low – three years trying to get it fixed.
 - Lab is lacking storage space for files.
 - Reaching overhead for heavy loads all day long.
 - Equipment / materials stored in the halls in new building.
 - Action only happens once people are injured.
 - Beds, wheelchairs, lifts and equipment are not well maintained.
 - Telephone headsets needed for those using phones for significant periods of time.
 - Workstations are reviewed only after a worker returns to work after an injury.
 - Workstation can't be modified without an OT assessment which delays action.
 - Access to ergonomic equipment or renovations is like asking for the moon.
 - BIPP is no longer promoted or offered consistently.
 - Restricted space – getting patient to a washroom is a nightmare.
 - Need to move wheelchairs and clutter to get to appropriate equipment in storage.
 - Laundry bags and garbage bags are always overfilled.
 - Hazards are identified but it takes so long to get something fixed we give up.
 - Nursing staff doesn't help recreational therapy to move patients.
 - Under pressure to move two wheelchair patients at once (one hand per chair – push one, pull one)
 - Time restraints demand moving two carts at one (push one, pull one)
 - Doors are heavy and difficult to open and close.
 - They knew about the hazards but nobody warned us. That's always the way.
 - It takes months and even years to get things fixed after sending a work order.
 - New chairs brought in after ergonomic assessment have caused bigger problems.
 - School didn't prepare me for how hard the work is.
 - Files are so tight people are injured retrieving them.
 - Teach me to type.
 - Lighting is so poor I can't see what I am doing.

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- Nobody asked my opinion when they set up my workstation. It's a pain, literally.
 - New staff get so little orientation they don't know what they should be doing.
 - We say we have policies and safe work practices but they are only on paper.
 - The building was never meant for this purpose. It just doesn't work.
 - There is nothing to protect us from falling off the roof.
 - Temperature control issues – for staff and public
 - The whole hospital is a disaster area.
 - Not enough space to do work.
 - Young people don't know what work is. I can't work with them.
 - Work stations throughout hospital have issues - size
 - New staff trained for only 3-5 shifts. That's not enough time to learn it right.
 - Driving and delivering with no consideration for ergonomics or other safety.
 - We find it hard to push trays but it doesn't seem to matter.
 - It takes so long to get things fixed, we get tired of waiting and work around it.
 - New equipment is sometimes worse than the old equipment.
 - We evaluated new mops but nobody ever asked my opinion about them.
 - Lifting is constant but because we aren't nursing it isn't seen as a priority.
 - Static movement – standing in one area for prolonged periods of time.
 - The dishwasher is a backbreaker.
 - You never know when someone will strike out at you so you are always tense.
 - We still do our work the way we did twenty years ago and it doesn't work.
 - Loading docks are
 - The parking lot is dark and I have to walk a long distance to my car.
 - We need more staff.
 - We don't have enough slings for the mechanical lifts so we don't use them.
 - We bring in policies because they exist somewhere else; they don't work here.
 - There are always staff who do things the old way.
 - We have four lifts but they do not always work.
 - The morgue trays are causing injuries all the time.
 - We need more security. I'm scared to death all the time.
 - Our home built as a personal care home but is now used for chronic care.
 - Our rooms were only made for one person but house two.
 - Pumping up stretchers is a real hazard.
 - Equipment problems – poorly maintained and we wait forever to get them fixed.
 - Rooms/washrooms too small – lack of wheelchair accessibility.
 - Cheap lights burn out too fast.
 - Try holding five children on a komatik and then we'll talk about ergonomics.
 - Utility rooms are important places – make them more compatible to our work.
 - The worse chairs are the ones I sit in to learn how to save my back.
 - Ergonomics is all about people doing stupid things.
 - Our new hospital has more unsafe conditions than the old one.
 - Practicing two person transfers sounds good but doesn't actually happen here.
 - Rooms too small to accommodate lifts and stretchers
 - Chairs for computers are not functional.
 - Too many electrical cords everywhere.

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- Proper seating height is impossible with my workstation.

Chemical / biological / hazardous materials:

- Formalin, nitrous oxide and preicide used with a surgical mask
- Breathing in dust from preicide burns my throat.
- Odours are terrible in the pathology lab.
- Smoke from cauterization is terrible. Smoke evacuators do not remove all fumes and sometimes they aren't used.
- Blood / body fluid exposure is a real worry.
- WHIMIS training was given a long time ago.
- We are supposed to use goggles and gloves when handling formalin, but most people do not because goggles are not provided.
- We should be using needleless devices but they tell us they are too expensive.
- Ventilation is inappropriate for the chemicals I use.
- Sharps disposal system inadequate.
- No windows to open means we have no ventilation.
- We find needles in the laundry and garbage all the time.
- Patients breathing out anaesthetic gases make workers tired.
- No fresh air/filtration system in the lab.
- Biological safety cabinets are not working.
- I failed fit-testing but nobody told me what I should do if I need a mask.
- Managers can't be responsible for what they don't understand.
- Chemotherapy precautions are not communicated very well.
- Waste disposal is a priority for us now.
- They spray pesticides around and don't even tell us or our patients.
- Blood/body fluid contact policy is old and outdated.
- Asbestos is present in our building but they pretend it isn't
- Mould is everywhere.
- I was fit-tested but there was no information to tell me what it means.
- Our building is infested with rodents and insects.
- Garbage is left for days before it is picked up.
- Cleaning of workstations / common areas on nursing units not always consistent
- Radiation is a big worry when protective equipment is old and worn.
- Leaks are everywhere causing mould and mildew.
- Mercury in thermometers is not necessary in this day and age.
- We had been using a chemical without knowing it was supposed to be diluted.
- Windows – windows in my office are crumbling/rotting.
- I worry about the asbestos.
- AIDS patients cause panic among staff, including nurses.
- Infection control is a big joke around here.
- Isolation room doors are always open and yet we gown up to go in. It's a farce.
- We had a scabies outbreak that went wild among staff.
- Not a good culture of keeping things clean/hand washing/blood exposure.
- I have no idea what is in the chemical products I am using. Nobody ever told me.
- I use unlabeled spray bottles for cleaning.

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- I do terminal cleaning on rooms without being told if I need protection.
 - Environmental services has changed cleaners three times in the past year with no information or training provided to staff.
 - Scent free policies are a big joke.
 - Increasing sensitivity to scents seems to be getting worse with age.
 - Outdated drugs are not being disposed of properly.
 - Increase in allergies and sensitivities among staff.
 - No training in disposal of biomedical waste.
 - I get a headache every time I come to work. I go home and I am fine.
 - We should buy more premixed products to reduce exposures.
 - Air quality is poor – people are tired and stuffed up all the time.
 - Air exchange is inadequate but nothing is being done to fix it.
 - Air quality testing results are always the same.
 - Why is MRSA a big deal in hospital but not in long-term care?
 - No isolation rooms – contain patients as best as you can. No sinks in rooms.
 - Ventilation in small offices is terrible and no windows.
 - The smell of cigarette smoke makes me sick.

Other

- Lack of security is a big problem around here. People wander in at all hours.
- Families create big problems for us. They call the shots and our safety suffers.
- Travel policies put our health and safety at risk.
- Conflict between departments makes for an unhealthy, stressful environment.
- I can't even get a pair of gloves for my work.
- Employee safety doesn't matter as much as patient safety.
- Shift work is hard. We need assistance to help us cope.
- We need more orientation that includes safety.
- A workshop or area to fix things would be nice.
- Hearing conservation assessment done ten years ago. No action taken.
- Going into environments with extreme behaviour – can be life or death situation.
- No cell phones/panic buttons
- Buddy system or better communication required when working alone.
- Poor working relationships – lack of communication.
- One shift gets educated on safe use of equipment; the other doesn't.
- Regionalization has taken away managers, which reduces safety support.
- Community visits with no link to the hospital.
- Working alone in basement all day long.
- Regionalization has made things worse.
- Lack of manager presence has made conditions deteriorate.
- Water is not fit to drink.
- No protective care unit.
- Problems regulating water temperature in tubs.
- Brand new shower room with no heat in the room and the room is tiny.

What do you believe a safety culture is? What needs to happen for a safety culture to exist?

- Everybody working together.
- Universal precautions must become second nature.
- More safety consciousness at all levels in the organizations.
- Where everyone in the organization is serious about safety; it's not just talk.
- Education, education, education.
- Cooperation and collaboration.
- Empowered leaders to provide safety leadership.
- Everyone in the organization taking an active role to promote safety.
- Everyone from top management and the bottom employee having the same focus.
- Education and orientation with resources available to deliver good programs.
- Safety program.
- Understanding ergonomics
- Let people have power to do things / let managers have time to do things.
- Workplaces where people consider the outcomes of their actions.
- A place where co-workers look out for each other.
- No injuries.
- Feeling free to voice concerns.
- Being thanked for reporting a hazard.
- When a workplace injury is considered as unacceptable as impaired driving.
- When health and safety is resourced full time

What do you feel are the main health and safety issues here?

- Staff shortages.
- Rushed/overworked/ heavy workload.
- Too many injured workers being accommodated.
- Aggression in emergency department.
- Biological exposure – infectious diseases, contaminated work areas.
- Strains, sprains and soft tissue injuries.
- Training and orientation lacking for safety
- Lack of space.
- Stress issues brought on by staffing.
- Verbal abuse over the phone because of wait times.
- The unfair treatment of people.
- Unfamiliar equipment and medications.
- General lifestyle issues – smoking, diet, exercise.
- Regionalization
- Money is more important than safety.
- Need to jump over hurdles to fix even the smallest, most common sense issues.
- Lack of leadership/advocacy.
- Lack of morale (“Morale is down in people’s boots”)
- Leaders don’t listen to front line workers.
- Forms and reporting systems are not user friendly.
- Lack of storage space.

What health and safety programs exist in this organization? Are these programs effective?

- BIPP (trained 7-8 years ago/10-15 years ago)
- WHMIS
- None that I know of.
- Taught basic body mechanics after an injury.
- Employee wellness – vaccinations
- Emergency preparedness – two afternoons a month.
- Bariatric patient and equipment training.
- Staff immunizations, flu vaccine.
- Colour code emergency system.
- OH&S committee.
- Radiation safety committee.
- Employee wellness.
- Employee and Family Assistance Program.
- Hand washing program
- Fire safety program.
- CPR
- SARS awareness.
- IPP – pretty much the same as BIPP
- Non-violent crisis intervention
- Near miss reporting
- Only reactive programs, none that are proactive.
- Return to work.
- Occurrence reporting.
- None!
- Fit-testing
- Radiation safety training
- Working from heights
- TDG – by road and air

Who is responsible for safety here?

- Everyone
- Managers
- OH&S committee.
- OH&S department
- Yourself – you're number 1.
- Union
- Wellness staff.
- Safety officers.
- All staff and contractors and students
- We all are, but authority should come from the top of the pyramid.
- My department manager.
- Staff health.

-
- Human Resources.
 - It changes so frequently.
 - Infection control.
 - All workers / managers

Is there consultation surrounding new work processes and new equipment? Is this followed by an evaluation to determine its impact on safety?

- Goes on tender. Whoever provides the cheapest bid gets their equipment brought in for assessment. Sometimes opinions about the equipment matter, sometimes they do not.
- Main concern is compatibility with existing equipment.
- New procedures are implemented as time permits.
- No consultation when recovery room was renovated.
- Never ever consulted.
- Product evaluation committee seeks input.
- There is very little consulting with people involved in new work processes and new equipment. There is an informal evaluation process.
- There is consultation, but not sure if there is evaluation.
- It's haphazard.
- No. A lot of our equipment may change but works the same so not a lot of need for that.
- No consultation takes place with frontline workers – occurs with managers. When it gets back to workers the decision is made.
- No ergonomic evaluation of new equipment.
- New birthing tub installed – not used because appropriate due to no consultation.
- New x-ray table installed which is too high and can't be used – no consultation.
- Sometimes maintenance is consulted.
- No evaluation process - stuff just shows up.

From an organizational perspective, rate the importance of safety in your workplace, on a scale of 1 to 10.

- Ratings provided along the entire rating scale.
- More patient safety focused than worker safety focused.
- I would give it a 9 out of 10 but if I was an employee I would probably say 4 because we see things that are happening but employees don't.

During the course of your daily work activities, where does OH&S sit on your list of priorities?

- Not as far up as it should because we are too busy.
- Its always there – I don't want to injure my back or shoulder.
- Wear and tear is starting to show because we're older, so you become more conscious of trying to help each other.
- Right on the top.
- People looking out for somebody else but not themselves.
- When injured – that's when they change their mindset.

-
- I need staff to feel I take this seriously in both support of their concerns and enforcement of safety procedures.
 - I'm vigilant – accused of being over vigilant at times.
 - We are always in a rush so it falls by the wayside.
 - I've been injured before so I watch out for myself and the person with me.
 - Minimal
 - No time for safety.

What are the consequences of having a workplace that is unsafe and unhealthy?

- More injuries.
- Litigation.
- Staff shortage – people not always replaced when off.
- People get run down and tired.
- It filters down – the “don't care” factor.
- Workload imbalance in high injury departments.
- Increased sick leave.
- Resentment of people on ease back.
- Poor patient care.
- Decreased productivity.
- Increased workplace injuries.
- Occupationally induced hearing loss.
- Increased patient injuries
- Lost time
- Negative impact on morale.
- Harm.
- People become disillusioned
- Costs increase.
- Loss of service to people who need it.
- Attendance problems.
- Issues around stress
- Unhappy staff, low morale
- Increased stress
- No time to chat with residents or co-workers.

Are all incidents and/or near misses reported? Why? Why not?

- Most definitely. It's been ingrained in us.
- Incidents – yes. Near misses – no.
- People feel that if nothing happened it's not worth the paper work.
- Too busy to fill out an incident report.
- If you figure you can get over it why bother? Use sick leave.
- When you're off on WCC it's as though you're being penalized for being injured.
- Use sick leave instead of WHSCC – there is no loss of pay.
- We are told to report incidents, but not near misses
- Most incidents are reported.
- People are using safety forms – they work!

-
- Usually, but not always. Time not there to do – many intend to, but gets put on lower priority for the day

If you were offered the same job elsewhere, would you leave?

Responses split between yes and no.

Describe a typical staff meeting. Is occupational health and safety on the agenda?

- I have never been to a staff meeting.
- Once a month. Sometimes discuss OH&S.
- Bitch session.
- No formal meetings; no formal agenda.
- OH&S first on the agenda.
- Being talked at / blamed – it's not a meeting.
- Frustrating. Does not occur often. OH&S not on agenda when there is one.
- Pretty casual – small/young department.
- Once a month – no standing agenda. OH&S doesn't come up.
- Rarely happens.
- Quarterly – discussed if something comes up
- Not usually.

Describe a situation that makes it necessary to ignore safe work procedures.

- Emergencies.
- Elevators.
- Patient falling.
- Patient priorities.
- Immediate first aid to save life
- Transportation:
 - Accompanying smoking patient
 - No seatbelts
 - Erratic driving during emergency
 - Condition of vehicles.
- When things have to be done.
- Time constraints.

How are safe work habits acknowledged?

- With tea buns.
- They aren't.
- Through accreditation.
- Performance appraisal

Do you feel valued by your organization?

- No – staff were charged \$5 for their appreciation dinner.
- Yes, at times.
- We are not even valued enough to get a free Christmas dinner.

-
- I got my 20-year ring and no one came to the ceremony.

In your opinion, is disciplinary action appropriate for safety violations? Why? Why not?

- Yes, if it is a blatant violation.
- Depends on circumstances.
- Yes because it forces responsibility/ownership of what you do.
- We need a culture of repairing poor behaviour.
- Yes, but progressive and depending on the severity of the infraction
- Yes, with the appropriate process in place
- Definitely.
- Part of safety culture thing – any other policy violation is enforced
- Not in isolation of other things.
- Need to know there is a consequence.
- If awareness wasn't there in the beginning, doesn't seem right to penalize.
- Don't think so because of the condition of the building.
- It would depend on the severity of the violation.

What do you do when you observe an unsafe *condition* (i.e. something in your environment)?

- Remove equipment from use and call biomedical department.
- Report it to appropriate personnel.
- Correct or report it immediately to appropriate department manager.
- Generally try to ensure its not going to harm someone right away.
- Fix it where possible.
- Tell co-worker/supervisor/contact maintenance.
- Complete a maintenance requisition.
- Complete a safety concern form.
- Tag-out.

What do you do when you observe an unsafe *act* (i.e. an action)?

- Depends on how often it happens.
- Usually report to manager.
- Intervene and explain observation and possible outcomes
- Tell them “you're going to be sorry for that!”

Think about an accident or incident in your workplace. Is it likely to happen again?

- Yes (predominant response).

Do you feel comfortable speaking up when something doesn't seem right Why? Why not?

- Yes.
- No, the backlash is not worth it.
- I speak to any one who will listen.
- No. Nursing culture is not well positioned to tolerate a lot of assertiveness.
- Not always, because I don't think we get listened to. No follow-up.

-
- CEO has staff forums – no one speaks.

Is there co-operation, respect and good working relationships among different disciplines and departments.

- No.
- There are times when it boils down to lack of communication.
- Yes.
- People are not feeling real good here right now
- Very poor working relationships.
- Morale is really bad.
- Animosity is everywhere.

Why do organizations promote workplace wellness programs (fitness, smoking cessation)?

- Save money.
- Keep workers on the job.
- So we won't go off.
- To reduce sick leave.
- For our personal well-being.
- Promote healthy lifestyles.
- Benefits the organization.
- To increase morale, decrease sick leave, and for a healthy staff and workplace.
- Quality of life. Fitness and physical competency should be a health and fitness standard.
- Cost reduction
- Healthier individuals better for the group and for the clientele.
- Affects productivity.
- Morale
- Better health
- Get more work out of us.
- Help to promote wellness among workers.
- Decreasing sickness and increasing productivity.

APPENDIX B

**Healthy Workplace Initiative:
Creating a Culture of Safety
Employee Survey Report August 2006**



Healthy Workplace Initiative: *Creating a Culture of Safety*

Employee Survey Report

August 2006

Prepared by



National
Quality
Institute

Institut
national
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Appendices:

1. Additional Resources, Elements of a Healthy Workplace and Drivers for Sustaining a Healthy Workplace Culture
2. Effective Practices in High Performing Organizations
3. Comparative Charts – Department-wide, Rotating vs. Non-Rotating Shift
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EXECUTIVE SUMMARY

Creating a Culture of Safety is the title given to a Healthy Workplace Initiative in the province of Newfoundland and Labrador that has been mandated to research issues related to occupational health and safety and workplace wellness in the health and community services system.

Employees throughout the provincial healthcare system were invited to complete the National Quality Institute (NQI) Employee Satisfaction Survey as one element of the Healthy Workplace Initiative research activities.

The NQI survey tool is used to assess employee satisfaction, perception of workplace fairness, physical environment and employee engagement.

The survey tool is based on the *Canadian Healthy Workplace Criteria*.

The survey tool includes **elements of a healthy workplace** (Appendix 1), namely:

- Physical environment and occupational health & safety
- Health and lifestyle practices
- Workplace culture and supportive environment

In addition, it is based on the **drivers of excellence** (Appendix 1):

1. Leadership
2. Planning
3. People focus
4. Processes

This is the first NQI survey report and therefore there has been no comparative data provided from within the provincial health care system. However, NQI has provided comparative scores from the NQI Benchmark database for comparison purposes.

In Summary

Congratulations on choosing the National Quality Institute's employee survey which reports on the organizational culture within the healthcare system in Newfoundland and Labrador. One employee said *"To have a healthy, happy workplace, managers need to listen to their employees more, and show that they are valued and respected"*. Another commented. *"Thank you for the opportunity to have my say about workplace health. Hope the information I have provided will help with your decision making in the future"*.

Some highlights include:

- 80% feel that they have a balance between work and personal life
- 68% feel management is flexible when urgent family matters arise
- 82% feel proud to work for their employer
- 81% feel they have a good relationship with their manager
- 70% feel that management leads by example with regard to safety
- 65% feel they are satisfied with the respect they receive on the job
- 84% feel they have the training they need to do their jobs safely

General themes came through in the comments. Employees:

- Feel there needs to be improvements made to the physical environment, such as space, temperature control, air quality, and equipment.
- Want to feel involved in planning, decision-making and improvement activities.
- Want to improve communication between management and staff.
- Want to be recognized (formally and informally) for good performance.
- Want respect and equal pay for equal work.
- Want transparency and better cross-functional teamwork.
- Want to feel that their suggestions are being appreciated, recognized, and implemented.

Total scores were tabulated system-wide, as indicated in the chart below. The NQI Benchmark is 60% (see Scoring page 9). The overall scores for the NL and community services system will be elaborated on throughout this report.

| | Total Score | Available Points | NLHCSS % | NQI Benchmark |
|--|--------------------|-------------------------|-----------------|----------------------|
| NL Health & Community Services System | 191 | 329 | 58% | 60 % |

NQI recommends that NL Health & Community Services System continue to flesh out the issues raised in this survey, especially with regard to the list of comments in Appendix 15. Surveys are only one mechanism to obtain feedback from employees. *It is recommended that supplemental feedback be sought due to the low response of participants in this survey.* It would assist in moving forward to:

- Feedback the results of the survey to employees.
- Conduct focus groups so that employees know management is serious about listening to them.
- Based on survey results, comments and focus group suggestions, create an action plan for implementation.
- Review recommended Path Forward on Page 30.
- Repeat survey each year to ensure trends are improving.
- Embark on a formal continuous improvement program such as National Quality Institute's Progressive Excellence Program - NQI PEP® for a Healthy Workplace.

PARTICIPATION

1935 employees completed the survey.

EMPLOYEE GROUPS

| | Responses |
|---|-------------|
| RN/ Nurse Practitioner | 633 |
| LPN | 430 |
| Support Staff | 375 |
| Clerical Staff | 114 |
| Allied Health Professional | 164 |
| Administrative Staff | 36 |
| Diagnostic Staff | 84 |
| Supervisor/Manager/Director/Senior Executive | 99 |
| Company Total | 1935 |

WORK SHIFTS

| | Responses |
|-----------------|-------------|
| 8 Hours | 760 |
| 12 Hours | 912 |
| Other | 263 |
| Total | 1935 |

ROTATING SHIFTS

| | Responses |
|--------------|-------------------------|
| YES | 1067 |
| NO | 865 |
| Total | 1932¹ |

YEARS OF SERVICE

| | Responses |
|------------------------------|-------------------------|
| Less than 1 year | 52 |
| 1 to 3 years | 131 |
| 3 – 5 years | 136 |
| 5 – 10 years | 335 |
| Greater than 10 years | 11 |
| Company Total | 1933¹ |

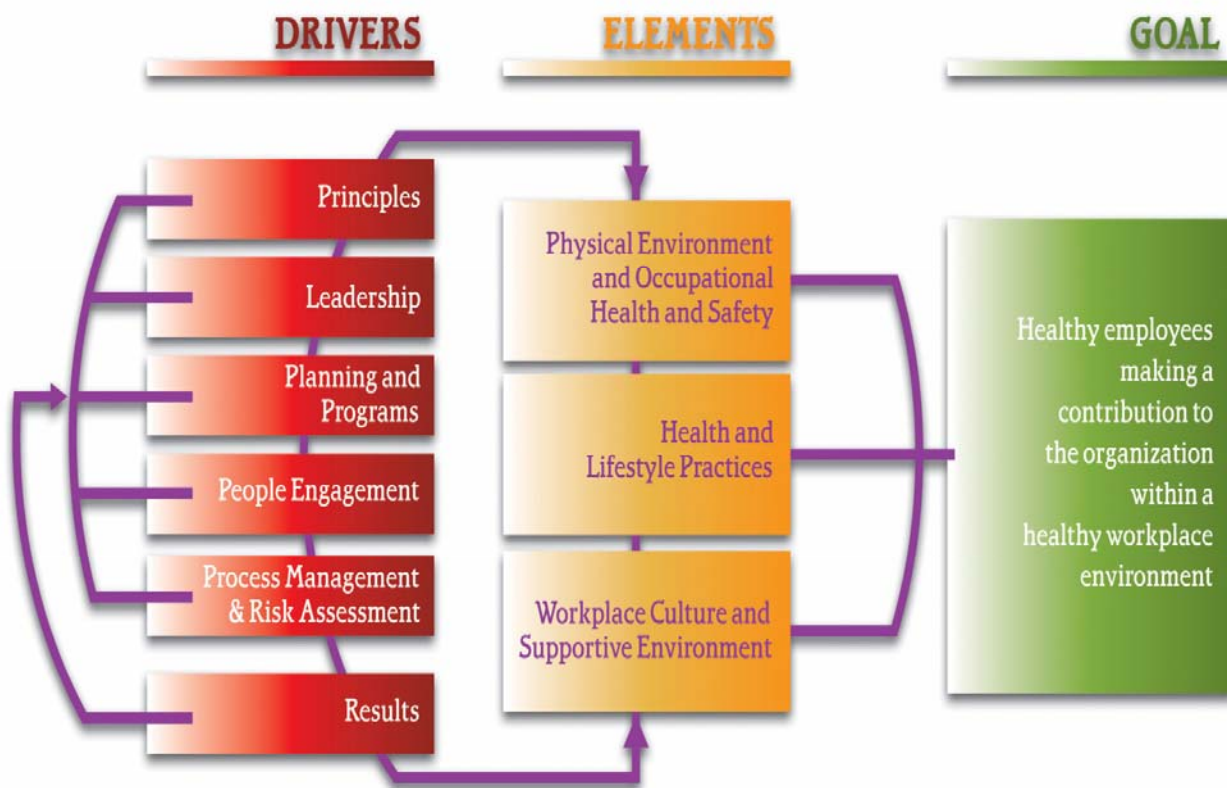
GENDER

| | Responses |
|---------------|-------------------------|
| Male | 269 |
| Female | 1665 |
| Total | 1934¹ |

¹ Not all answered the question

Canadian Healthy Workplace Criteria

The Canadian Healthy Workplace Criteria was developed in 1998 by the National Quality Institute, Health Canada and experts in employee health and wellness across Canada. It was revised in 2005 to reflect elements such as mental health in the workplace. The framework is used as the criteria for the prestigious *Canada Awards for Excellence*, and forms the basis for the NQI Progressive Excellence Program (NQI PEP®), a four-staged implementation tool and roadmap for organizations to implement a healthy workplace (appendix 1).



INTRODUCTION

In 2006, the Healthy Workplace Initiative: *Creating a Culture of Safety* contracted the National Quality Institute (NQI) to conduct the very first system-wide employee satisfaction survey within the health and community services sector in Newfoundland and Labrador.

The standard NQI questionnaire was used with some customization to the questions. The survey was based on the NQI Canadian Healthy Workplace Criteria.

The purpose of the survey was to receive input from employees about their perception of the working environment within the health and community services system. The results were analyzed and NQI recommends that this analysis form part of the research database currently being compiled by the Healthy Workplace Initiative: *Creating a Culture of Safety*.

NQI further recommends conducting focus group sessions to confirm, validate and clarify the results of the survey.

The Objective

The objective of this report is as follows:

- To identify strengths and opportunities
- To allow employees to provide anonymous feedback
- To create a baseline for future surveys
- To provide a baseline for an action plan for improvement
- To provide benchmark data and trend data
- To provide research data

Scope of this Report

This report outlines the summary results as they pertain to the provincial health and community services system as a whole.

Summaries of scores by employee group are appended to this report. Employee comments were grouped together intentionally so as not to single out individuals and/or “point fingers” at particular groups.

It is important to note that strengths and opportunities as identified in this report are not comprehensive and were taken from survey results only. NQI recommends that further investigation be undertaken through employee focus groups and similar research activities.

SCORING

Each question had a scale of 1 – 7, with 7 being “strongly agree” and 1 being “strongly disagree”.

For the graphics displayed in this report, we have indicated the following:

| | |
|------|---------------------|
| 1 | Not satisfied |
| 2, 3 | Somewhat satisfied |
| 4 | Satisfied |
| 5 | Very Satisfied |
| 6, 7 | Extremely satisfied |

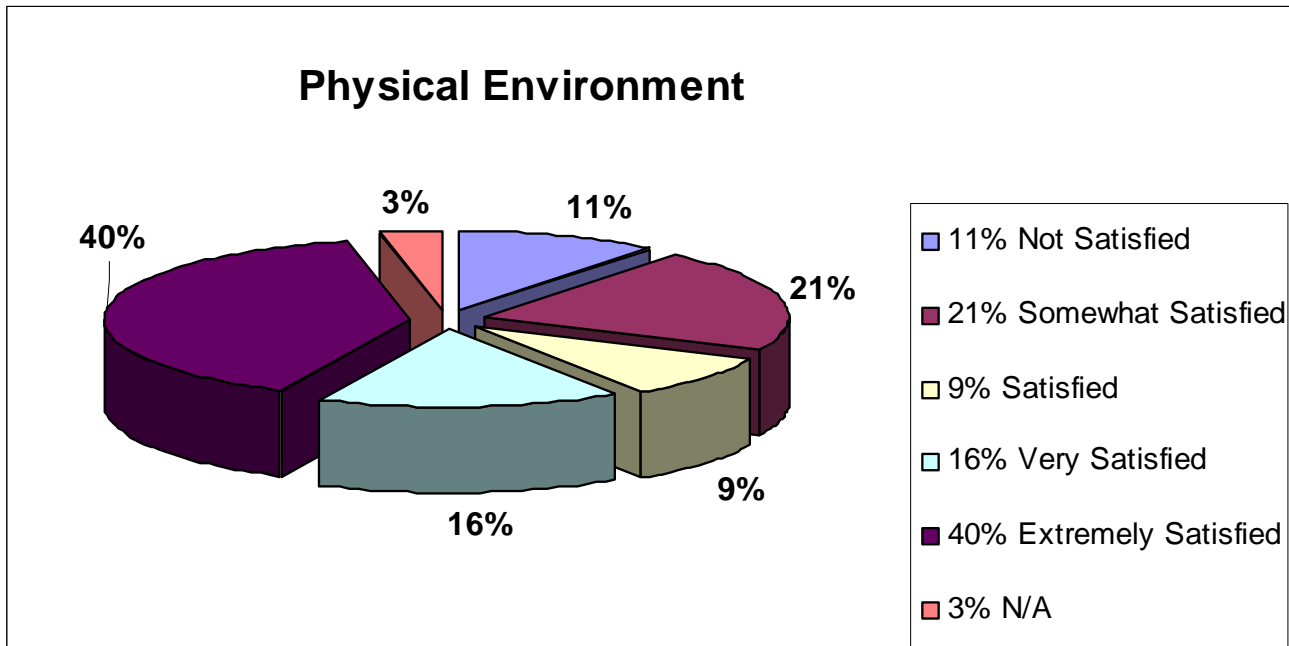
In most cases, we have compared scores for the NL Health and Community Services system to the NQI Benchmark. The NQI Benchmark is the average score for all participants collectively in the NQI survey database. The Benchmark is not sector specific and includes all types of organizations.

This was the first survey completed by the NL Health and Community Services sector on the NQI system and therefore we are not able to provide comparative data from previous years.

We recommend that this survey be conducted every 12-18 months on an ongoing basis as part of an overall strategy for improving employee health and well-being.

SUMMARY RESULTS OF SURVEY (All participants)

1. Physical Environment and Occupational Health & Safety



Overall Physical Environment scored 65%, compared to the NQI Benchmark of 73%.

This category attracted many comments from staff. Comments included:

- *There is an overall effort to improve the physical environment*
- *Wards are too small, supplies in hallways, poles, monitors and stretchers...*
- *We are trying to improve in this area and have consulted a professional in ergonomics*
- *Protective eyewear not provided in patients' rooms*
- *Outdated equipment...vital sign equipment that does not work...wheelchairs missing a foot-rest*
- *Very poor air quality during warm weather*
- *Takes too long to get things done..... Things could be fixed a lot faster*
- *Lack of resources (such as cell phones) which promote safety*
- *More ergonomic assessments and equipment, to follow through with recommendations*
- *Educational opportunities are made available*
- *Not enough storage which causes over crowding....too crowded*
- *Parking lots often icy in winter*
- *Plaster is falling off and ceiling tiles are getting soaked with water leaks and falling down*
- *Any concerns are readily addressed by our Wellness Nurse*

NOTE: Refer to appendix 15 for full listing of employee comments.

| Physical Environment | Total | Available | NLHCSS | Benchmark |
|--|-------------|-------------|------------|------------|
| | Score | Points | % | NQI |
| I understand the emergency procedures should I need to act quickly | 5.7 | 7.0 | 81% | 79% |
| The furniture and equipment is ergonomically designed to minimize strain | 4.0 | 7.0 | 57% | 57% |
| The lighting, air quality, temperature and noise levels are good | 3.4 | 7.0 | 49% | 69% |
| Injured employees are accommodated as needed | 4.9 | 7.0 | 70% | 86% |
| I am made aware of health and safety programs that affect me at work | 5.0 | 7.0 | 71% | 74% |
| Unsafe conditions in the physical environment are corrected in a timely manner | 4.2 | 7.0 | 60% | n/a |
| There is adequate space to perform my duties safely | 4.3 | 7.0 | 61% | n/a |
| I have the supplies & resources I need to adequately perform my duties | 4.8 | 7.0 | 69% | n/a |
| TOTAL | 36.3 | 56.0 | 65% | 73% |

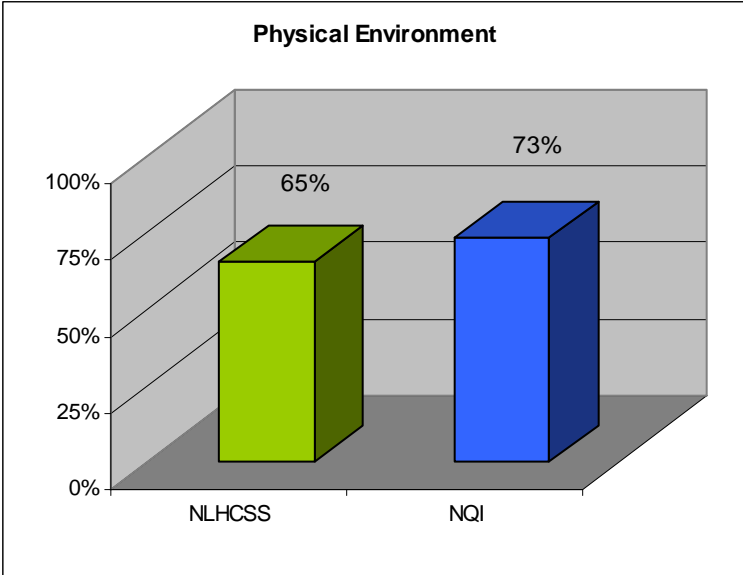
Strengths:

- Overall 65% of employees are satisfied to extremely satisfied with the physical environment
- 88% say they are satisfied to extremely satisfied with understanding the emergency procedures should they need to act quickly
- 77% are satisfied to extremely satisfied that injured employees are accommodated as needed
- 78% agree that they are made aware of health and safety programs that affect them at work
- 66% agree that they have the supplies and resources they need to adequately perform their duties (25% were less than satisfied)

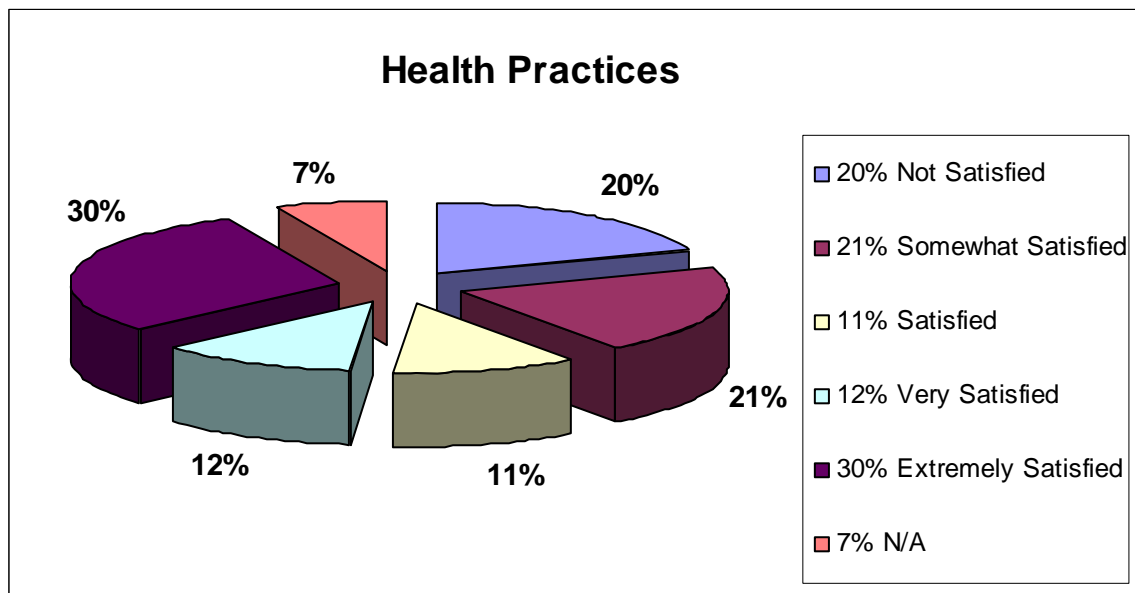
Opportunities:

- 41% disagree that the furniture and equipment they use is ergonomically designed to minimize physical strain (57% are satisfied)
- 54% disagree that the lighting, air quality, temperature, and noise levels are good (20% are extremely satisfied)
- 37% disagree that unsafe conditions in the physical environment are corrected in a timely manner (31% are extremely satisfied)
- 38% feel that there is not adequate space to perform their duties safely (39% extremely satisfied)
- 25% say they were satisfied to less than satisfied with the supplies and resources needed to perform their duties

Compared to NQI Benchmark



2. Health and Lifestyle Practices



The score for Health and Lifestyle Practices scored 55% where the NQI benchmark is 60%. Comments from employees included:

- *My work environment is good. I feel supported by my manager and respected.*
- *[Need] healthier food choices in the cafeteria....fries available but not salad*
- *Often we [staff] could help things run smoother ...we may have some ideas and positive input*
- *Visitors cannot visit if they have a cough but we come to work with colds and flu..*
- *Have healthy eating programs and many other health-related programs*
- *If there was more flexibility around meal times and break times, a person could walk during lunch*
- *There is no EAP program....[and also] EAP is a very worthwhile program*
- *Flexible schedule is good as well as support and responsiveness in event of family crisis*
- *Concerns regarding workload are being addressed*
- *Stress in the workplace is very high*
- *There is no accommodation made for shift workers*
- *Vending machines should be more health orientated supplying more juices and less colas and chips*
- *Moving in the right direction as we now have an Employee Health and Wellness division*
- *I believe the organization has done very well providing programs*
- *Want on-site fitness facilities*
- *Employee health programs offered (weight watchers, smoking cessation, back care) but limited take-up by employees*

| Health Practices | Total | Available | NLHCSS | Benchmark |
|---|--------------|------------------|---------------|------------------|
| | Score | Points | % | NQI |
| There is an adequate amount of help available on health issues such as stress | 4.5 | 7.0 | 64% | 53% |
| My work is not too stressful | 3.5 | 7.0 | 50% | 49% |
| I have balance between my work and personal life | 5.0 | 7.0 | 71% | 70% |
| I have adequate access to on-site fitness facilities, paid for by my employer | 1.9 | 7.0 | 27% | 66% |
| The organization provides equal/adequate programs for shift workers | 2.8 | 7.0 | 40% | 49% |
| We receive adequate information on health issues that affect me | 4.3 | 7.0 | 61% | 60% |
| Management is flexible when urgent family needs arise | 4.9 | 7.0 | 70% | 77% |
| | | | | |
| TOTAL | 26.9 | 49.0 | 55% | 60% |

Strengths:

- Overall 53% are satisfied with health and lifestyle practices
- 70% were satisfied to extremely satisfied with the amount of help available on health issues
- 80% are satisfied to extremely satisfied with the balance between work and personal life (19% are not satisfied)
- 66% are satisfied to extremely satisfied that they receive adequate information on health issues that affect them (32% extremely satisfied)
- 68% agree that management is flexible when urgent family needs arise (50% are extremely satisfied)

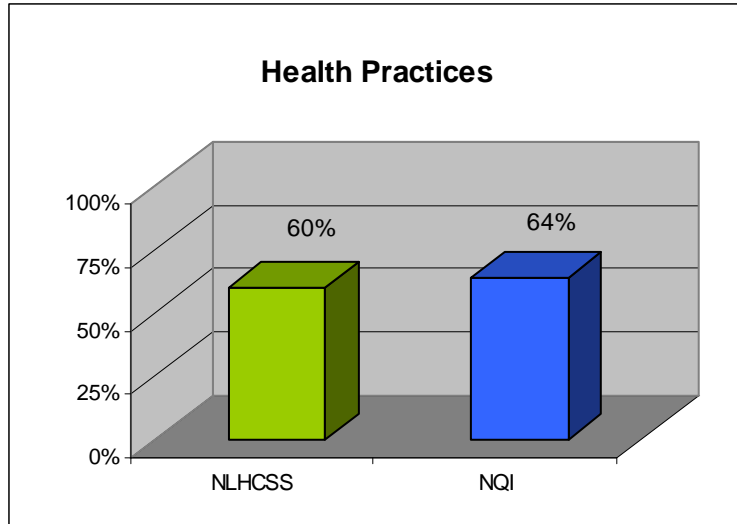
Opportunities:

- 53% say that work is too stressful
- 77% say they do not have adequate access to on-site fitness facilities with local health clubs, paid for by the employer
- 51% disagree that the organization provides equal/adequate programs for shift workers (21% answered "N/A")
- 32% feel that they do not receive adequate information on health issues that affect them (66% are satisfied to extremely satisfied)
- 27% disagree that there is an adequate amount of help available on health issues

For Consideration:

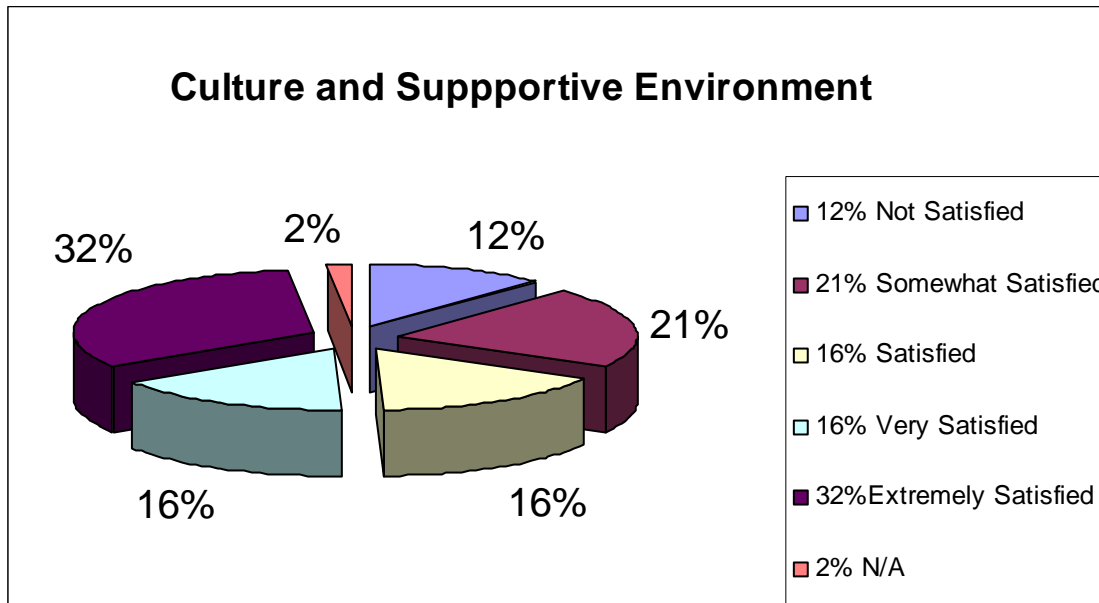
- Embark upon a formal healthy workplace program using the Canadian Healthy Workplace Criteria as the framework
- Include assessment of needs, e.g., flexibility of hours for physical exercise if feasible, etc.

Compared to NQI Benchmark



| How do you think your organization could improve the health & wellness of employees? | |
|---|-----|
| Introduce or expand flexible scheduling options | 11% |
| Communicate more openly with employees | 12% |
| Make more time available for physical activity | 10% |
| Provide or support stress control programs | 11% |
| Provide or support more social/family events | 8% |
| Get more employee input on how work gets done | 14% |
| Provide or support healthy eating program | 9% |
| Provide or support other programs that will improve employees' health | 11% |
| Encourage employees to spend time improving their health | 11% |

3. Workplace Culture and Supportive Environment



The overall score for Culture and Supportive Environment is 60% compared to the NQI benchmark of 64%. Comments from employees include:

- *Great working environment here. Management doing a very good job. They accommodate employees and try to do the best for all.*
- *Management open and supportive but sometimes feel overwhelmed themselves.*
- *Communication varies with managers.*
- *Love the job – not the supervisor. If supervisors learned how to respect employees and praise their work morale would certainly go up.*
- *My supervisor has been exceptional with me during any crisis.*
- *I have been through a lot of change in the past 20 years. I am proud to work [here] and I love my job. I would not want to be anywhere else in my career right now.*
- *It is discouraged to drop by management – the door is code locked – not a very open door policy.*
- *Door to management office has posted paper sign that reads “do not disturb”.*
- *Manager should spend more time on floor talking with staff.*
- *Morale is at an all time low. I said I would never fill out another survey because nothing gets acted on.*
- *Never had a staff meeting in 4 years. Lack of communication between staff and management.*
- *I am so happy to have a job and the department, and the people I work with are great and I love every day I work.*
- *The manager on the unit has to be the most understanding “human” I have ever encountered. This multi-tasked manager gets the job done with heart.*

| Culture and Supportive Environment | Total | Available | NLHCSS | NQI |
|---|--------------|------------------|---------------|------------------|
| | Score | Points | % | Benchmark |
| Management communicates effectively and regularly with employees | 3.7 | 7.0 | 53% | 59% |
| Management cares about employees | 3.7 | 7.0 | 53% | 57% |
| Management has an open door policy | 4.0 | 7.0 | 57% | 63% |
| Our workplace is free from discrimination and harassment | 4.5 | 7.0 | 64% | 67% |
| I am proud to work here | 4.9 | 7.0 | 70% | 74% |
| If offered the same job at another organization, I would choose to stay | 4.6 | 7.0 | 66% | 67% |
| | | | | |
| TOTAL | 25.4 | 42.0 | 60% | 64% |

Strengths:

- Overall 64% of employees are satisfied with the culture and supportive environment.
- 69% feel the workplace is free from discrimination and harassment
- 82% feel proud to work for their employer
- 72% of employees said that if offered the same job at another organization, they would choose to stay there (23% disagree)

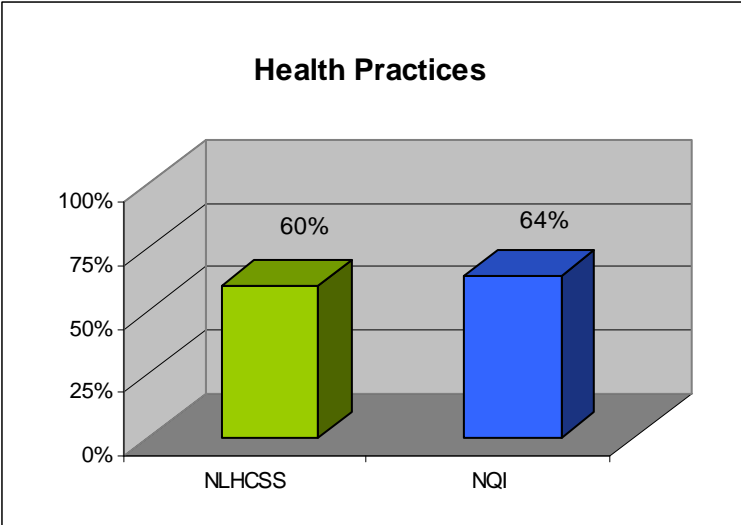
Opportunities:

- 47% of employees feel that management does not communicate effectively and regularly with employees (41% are very to extremely satisfied)
- 46% feel management does not care about employees (20% are extremely satisfied)
- 38% feel that management does not have an open door policy (27% are extremely satisfied)
- 30% disagree that the workplace is free from discrimination and harassment

For Consideration:

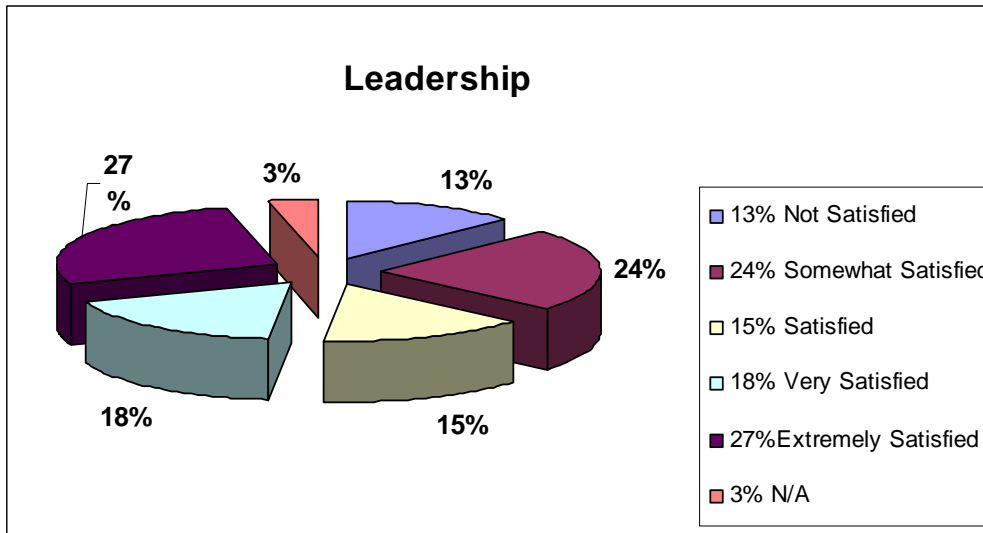
- NQI recommends that an assessment (audit) be conducted against the 3 elements of a healthy workplaces outlined in the Canadian Healthy Workplace Criteria.
- Involve employees in decisions for programs to address employee needs.
- Communicate regularly and in various ways.

Compared to NQI Benchmark



4. Leadership

This section focuses on those who have primary responsibility and accountability for the organizations' performance. For a healthy workplace system to be successful, it must be viewed as a line management task, supported through either direct involvement by senior management (notably in a small/medium sized organization), or through directives from senior management (in the case of a large organization). Good leadership is based on a foundation of ethics and values that serve to reinforce the development and sustainability of a healthy workplace environment.



Overall Leadership scored at 58% compared to the NQI benchmark of 58%. Employee comments included:

- *As far as I'm concerned, all my bosses are great!*
- *My manager attends to safety issues promptly and often identifies issues before they are identified by staff.*
- *We have wonderful leaders here. It is good to have a leader who genuinely cares for employees.*
- *If a problem is recognized, a solution and timeframe for resolution should be given.*
- *There has to be more of a team work approach. There is too much division between different categories of health care workers.*
- *Mental and physical stress – extreme staff overworked; unable to take rest breaks due to workload; no leadership on unit.*
- *My floor manager tries her best.*
- *Immediate manager approachable and easy to access. I see little of "senior management".*
- *More openness about organizational reorganization would be an asset.*
- *I find out more information from unionized staff first before being told by senior management.*

| Leadership | Total | Available | NLHCSS | NQI |
|---|-------------|-----------|------------|------------|
| | Score | Points | % | Benchmark |
| Management involves employees in decision-making | 3.2 | 7.0 | 46% | 51% |
| My manager welcomes ideas and suggestions and promptly follows up with me | 3.8 | 7.0 | 54% | 63% |
| Managers value the employees and the contribution they make | 3.5 | 7.0 | 50% | 54% |
| I receive enough technical training to do my job well and safely | 4.9 | 7.0 | 70% | 70% |
| Management participates in healthy workplace activities with employees | 3.5 | 7.0 | 50% | 50% |
| Management keeps employees informed about the state of the organization | 3.7 | 7.0 | 53% | 57% |
| There is a culture of teamwork and cooperation at my place of work | 4.2 | 7.0 | 60% | 64% |
| I have a good relationship with my manager | 5.0 | 7.0 | 71% | 57% |
| Management in my organization lead by example, with regards to safety | 4.4 | 7.0 | 63% | n/a |
| There is a culture of safety at my place of work | 4.4 | 7.0 | 63% | n/a |
| | | | | |
| TOTAL | 40.6 | 70 | 58% | 58% |

Strengths:

- Overall 60% of employees are satisfied with leadership
- 77% of employees feel they receive enough technical training to do their job well
- 81% feel they have a good relationship with their manager (48% are extremely satisfied)
- 70% agree that management lead by example with regards to safety

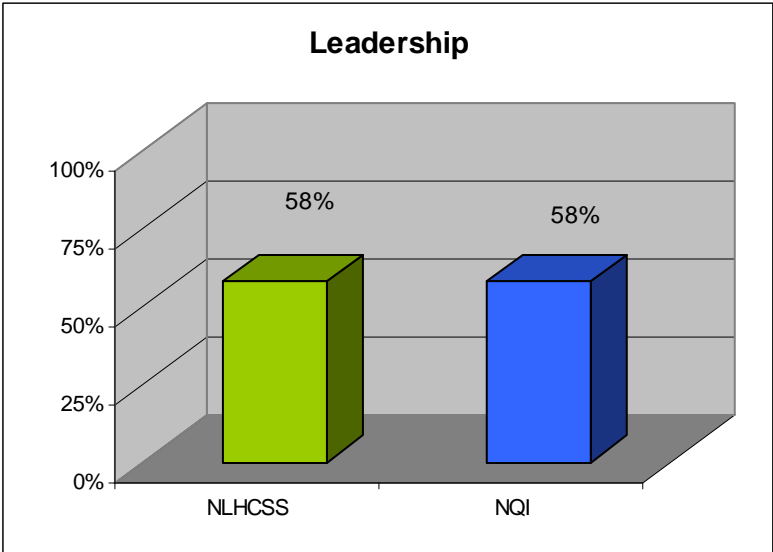
Opportunities:

- 57% feel that management does not involve employees in decision making (42% satisfied)
- 45% feel management does not welcome ideas and suggestions and does not follow up with them (53% are satisfied)
- 46% feel the “senior management team” do not value the employees and the contribution they make (51% are satisfied to extremely satisfied)
- 48% disagree that management participates in healthy workplace activities with employees (38% are satisfied)
- 45% disagree that management keeps employees informed about the state of the organization (53% are satisfied to extremely satisfied)
- 34% do not feel there is a culture of teamwork and cooperation at their place of work (64% are satisfied to extremely satisfied)
- 26% of employees feel management does not lead by example with regards to safety
- 25% disagree that there is a culture of safety at work (64% are satisfied to extremely satisfied)

For Consideration:

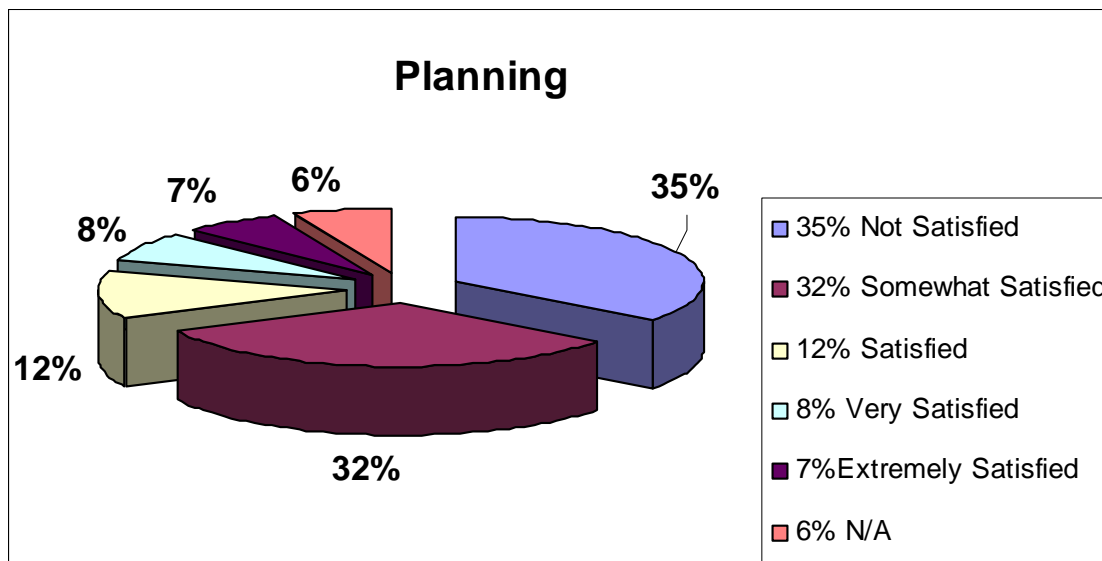
- Consider formal leadership training program for all levels of management if not already in place
- Improve communication at all levels
- Ensure open door policy is consistently applied

Comparison to NQI Benchmark



5. Planning

In a healthy workplace, a planning process should be in place for developing an overall Healthy Workplace plan for the organization as well as the design, activities and evaluation of integrated healthy workplace programs. Programs can cover a wide variety of issues and often impact one another. For example, a comprehensive wellness program should incorporate components such as healthy eating, enjoyable physical activity and a positive body image. One component alone is usually not sufficient to make up an overall program. In the same way, the three key elements of a healthy workplace - namely physical environment and occupational health & safety, health & lifestyle practices and workplace culture and supportive environment, build on one another to meet the needs of employees.



The score for Planning was 36% compared to the NQI benchmark of 45%.

Employee Comments included:

- *The organization has started a QPPE team in the past few months (staff input to try to improve our working conditions).*
- *When it comes to planning different things from the very basic things to more important decisions, many of the health care workers don't know about the changes until already in place.*
- *I would like to see a more site specific planning committee to plan wellness activities.*
- *Senior management needs to act more on the suggestions of staff regarding renovations because these are the people who will be working in this environment.*
- *The restructuring process and the creation of a corporate wide department focusing on quality enhancement and risk management should hopefully bring changes to areas where there are safety concerns and provide consistency throughout the region.*
- *Wellness surveys were conducted and filled out and results distributed to all. However, so far I have not seen any of the suggestions implemented.*
- *Our Division will be having a strategic planning session soon and I along with my co-workers will have the opportunity to express ideas regarding wellness initiatives.*

| Planning | Total | Available | NLHCSS | NQI |
|--|--------------|------------------|---------------|------------------|
| | Score | Points | % | Benchmark |
| I have input into planning for future changes in the organization | 2.8 | 7.0 | 40% | 49% |
| Management has conducted a formal needs assessment | 2.3 | 7.0 | 33% | 40% |
| I have input into wellness activities we have/have not implemented | 2.5 | 7.0 | 36% | 47% |
| TOTAL | 7.6 | 21.0 | 36% | 45% |

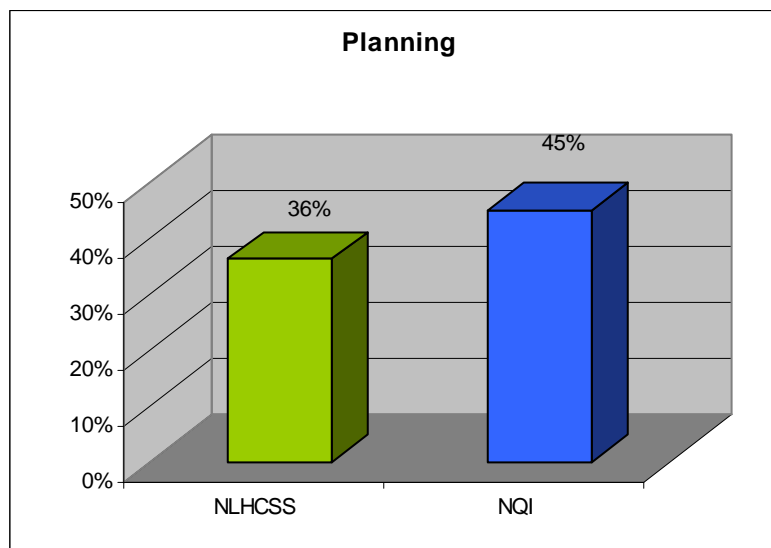
Opportunities:

- Overall 67% are not satisfied with planning process
- 64% of employees disagree that they have input into planning for future changes in the organization
- 73% felt that management has not conducted a formal needs assessment asking about preferences for well-being at work (22% were satisfied to extremely satisfied)
- 66% feel they do not have input into wellness activities that have/have not been implemented (25% are satisfied)

For Consideration:

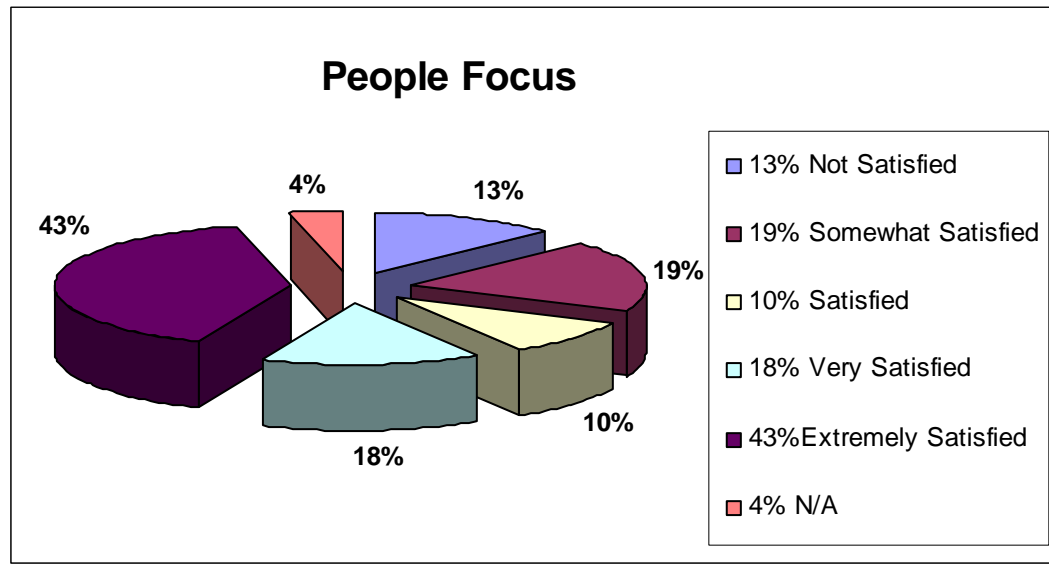
- Involve employees in planning processes
- Provide opportunities for employees to provide feedback and suggestions

Comparison to NQI Benchmark



17. Focus on People

A focus on people demonstrates efforts to foster and support an environment that encourages people to get involved in healthy workplace activities. Treating people with respect and trust, providing them with the opportunity to contribute ideas and speak out, without fear of retribution, on issues of concern (such as the organization's design and control of work) are important bases for developing a healthy workplace environment. If employees do not feel they have control over their work and have many demands on them stress levels rise and this affects their health and the health of the organization.



The overall score for People Focus is 63% compared to the NQI Benchmark of 66%.

Comments from employees included:

- *We need clear goals and objectives.*
- *Personal safety training should be a must for front line social workers.*
- *How about a thank you now and then?*
- *My performance may not be reviewed annually but my boss lets me know by her attitude that she is pleased with my work.*
- *Currently involved in change – efforts are being made to ease transition.*
- *It should be reinforced to all departments to treat every individual with dignity and respect.*
- *No recognition from employer – reward and satisfaction comes from contact with clients and co-workers.*
- *We are the lowest paid nurses in Canada.*
- *Although there is EAP program in place, I would not avail of it especially for a sensitive issue...deterrent that internal staff provide service.*
- *I work in an area where I see the manager maybe once every couple of months only by passing her desk.*
- *Pay equity.*
- *I have no job description... [others said] "other duties" far too broad.*
- *More training is needed.*

- *Never had a performance review..[Others said none in 12 – 15 years].*
- *Management treats you like a number...also avoid emails or returning phone calls.*
- *Staff needs to be consulted and a positive approach is needed so that staff can feel that they are valued employees and that their comments will be acted upon.*
- *Our policies and procedures have not been updated in years. Often things are just started with no written procedures or policy.*
- *I am new to management and work where staff has had little in the way of performance review, clearly written goals and objectives, or staff meetings. Staff is anxious about organizational change and as a manager I feel restricted in what I can tell them...and received no management orientation.*

| People Focus | Total | Available | NLHCSS | NQI |
|--|-------------|-------------|------------|------------|
| | Score | Points | % | Benchmark |
| I am satisfied with the fairness and respect I receive on the job | 4.3 | 7.0 | 61% | 64% |
| Management acts to solve problems in a timely manner | 3.9 | 7.0 | 56% | 60% |
| I feel like I have control over my day-to-day work | 4.5 | 7.0 | 64% | 69% |
| Employees have personal assistance if they need it such as an EAP | 5.4 | 7.0 | 77% | 74% |
| I have a current job description which outlines what is expected of me in my job | 5.2 | 7.0 | 74% | 72% |
| I have clearly written goals and objectives | 4.7 | 7.0 | 67% | 67% |
| I have the training I need to do my job safely | 5.4 | 7.0 | 77% | 79% |
| My performance is reviewed at least annually | 3.3 | 7.0 | 47% | 61% |
| I feel I am rewarded in terms of praise & recognition for the effort I put into my job | 3.3 | 7.0 | 47% | 56% |
| I am being paid fairly for my work compared to others | 3.8 | 7.0 | 54% | 59% |
| TOTAL | 43.9 | 70.0 | 63% | 66% |

Strengths:

- Overall 71% are satisfied with people focus area
- 65% of employees are satisfied with the fairness and respect they receive on the job (36% are extremely satisfied)
- 52% feel management acts to solve problems in a timely manner (23% are extremely satisfied)
- 68% say they satisfied to extremely satisfied with the control they have over their day-to-day work
- 84% agree that employees have personal assistance if they need it, such as an EAP (62% are extremely satisfied)
- 81% agree that they have a current job description which outlines what is expected of them
- 75% agree that they have clearly written goals and objectives (43% are extremely satisfied)
- 84% are satisfied to extremely satisfied that they have the training they need to do their jobs safely

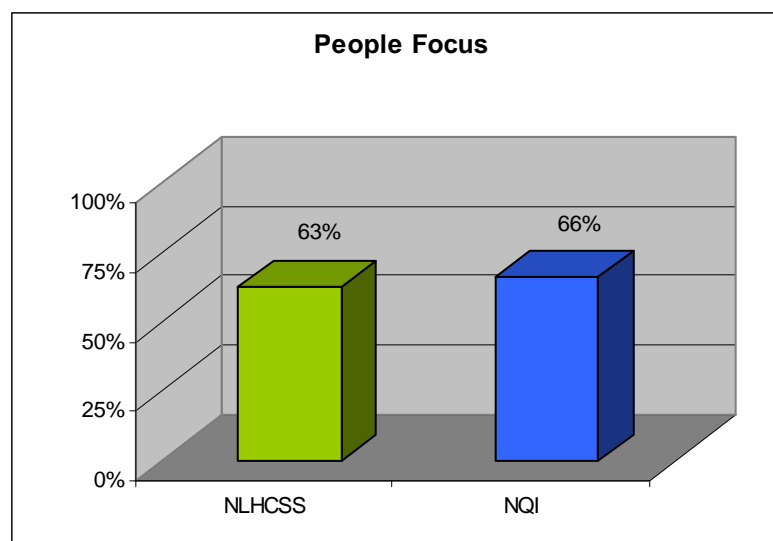
Opportunities:

- 34% are not satisfied with the fairness and respect they receive on the job
- 31% feel management does not act to solve problems in a timely manner
- 29% feel that they don't have control over their day-to-day work
- 55% disagree that their performance is reviewed at least annually (41% are satisfied to extremely satisfied)
- 55% of employees feel they are not rewarded in terms of praise and recognition for the level of effort they put into their job (42% are satisfied)
- 40% feel they are not being paid fairly for their work compared to others (52% are satisfied)

For Consideration:

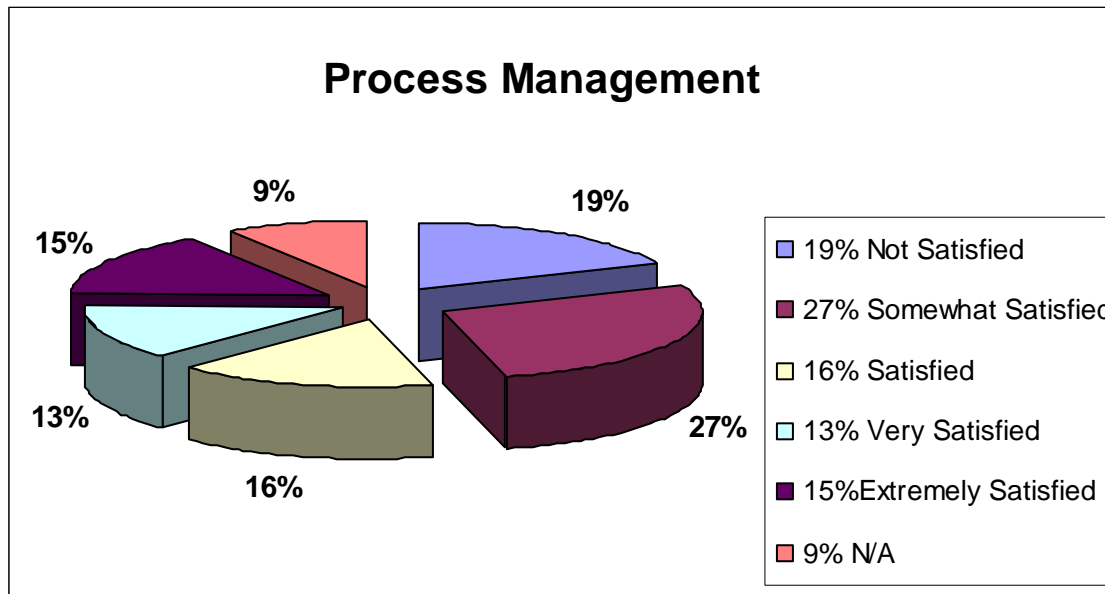
- Consider outsourcing EAP program to external party if usage is not as high as it could be.
- Ensure clear written goals and objectives by dept and by individual.
- Annual Performance management system.
- Review salary administration.
- Design and implement both formal and informal recognition systems, for individuals and teams.

Comparison to NQI Benchmark



18. Process Management

Processes that have a direct impact on a healthy workplace should be controlled and improved, notably those “key” processes that are critical to sustaining actions and a strong focus on employee well-being across the organization. Organizations that are successful in sustaining and improving a healthy workplace move well beyond the “awareness and information” stage of their programs towards a focus on skill development and behaviour change that help to reinforce a healthy workplace. These organizations have also created a supportive environment that helps to maintain and improve such a focus.



The overall score of Processes was 49% compared to the NQI Benchmark of 53%.

Employee comments included:

- *Making progress with quality initiatives and such but there is still a long way to go.*
- *Very poor communication therefore decisions and policy changes are not directly passed on to us, we usually have to discover them when the situation confronts us.*
- *We have many PIT teams here to improve overall culture of safety for everyone.*
- *Being involved in the process means time taken from regular duties and responsibilities. This is often not taken into consideration.*
- *The multidisciplinary teams communicate very well and have a positive exchange of information making recommendations for resident care and addressing other workplace issues.*
- *Barriers need to come down, we are all one – acute and long term care – there needs to be a team building session within the departments so that all managers/supervisors/directors can feel like a team and operate effectively.*
- *Our department is working with other departments to establish guidelines e.g., equipment purchases to meet ergonomic guidelines.*
- *I am involved with a program called QPPE – Quality Professional Practice Environment.*

| Processes | Total | Available | NLHCSS | NQI |
|--|-------------|-------------|------------|------------|
| | Score | Points | % | Benchmark |
| I am involved in quality improvement initiatives such as problem solving teams | 3.2 | 7.0 | 46% | 50% |
| When new processes are implemented, impact on employees is taken into account | 3.5 | 7.0 | 50% | 49% |
| We work in teams across different functions to solve problems & make changes | 3.6 | 7.0 | 51% | 59% |
| TOTAL | 10.3 | 21.0 | 49% | 53% |

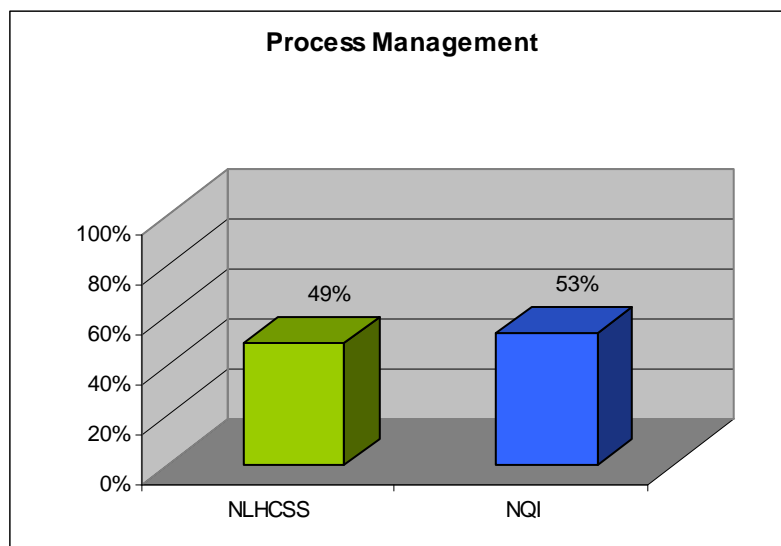
Opportunities:

- 50% of employees disagree that they are involved in quality improvement initiatives such as problem solving teams (38% are satisfied, 12% responded “N/A”)
- 46% report that when new processes are implemented, the health impact on employees is not taken into account (48% are satisfied)
- 42% of employees disagree that they work in teams across different functions to solve problems and make changes (49% are satisfied)

For Consideration:

- If not already underway, consider formal training in process improvement.
- Continue to involve staff at all levels across all functions in process improvement.
- Document and communicate any changes in processes.
- Focus on “prevention” not “correction”.

Comparison to NQI Benchmark



SUMMARY OF SCORES

| | Total Score % | NQI Benchmark % |
|---|------------------------------|--------------------------------|
| Physical Environment | 65 | 75 |
| Health and Lifestyle Practices | 55 | 60 |
| Culture and Supportive Environment | 60 | 64 |
| Leadership | 58 | 58 |
| Planning | 36 | 45 |
| People Focus | 63 | 66 |
| Process Management | 49 | 53 |
| Company Total | 58 | 60 |

PATH FORWARD

The results of this survey are a base line for planning.

A. *Validating Information:*

Many employees took the time to add comments. Noted opportunities should be fleshed out in more detail with employee representatives to ensure a clear understanding of the issues. We recommend setting up a few focus groups to flesh out the issues and help understand where to go from here. Most importantly, share the results of the survey and communicate any action taken as a result of the data.

B. *Base Line*

This information will now add to trend data, from which to measure improvements in following years. The NQI Criteria (outcomes driver) is all about collecting data, tracking year over year, and most importantly using the data for improvement plans.

C. *Other Tools*

Consider complimenting this survey with other tools such as an Employee Health Risk Assessment and an audit against the 3 elements of a healthy workplace. This will give specific information about health risks and employees' needs and wants and will identify where the organization is vulnerable and areas of improvement needed. Valuable information can be gleaned from this and programs built to address these risks.

D. *Improvement Plan*

There is a need to formalize an improvement plan – noting the issues and opportunities, “Smart objectives” (specific, measurable, attainable, relative & time bounded), action plans, time lines and accountability. This plan will form part of the organization’s Healthy Workplace Plan and will be incorporated into the organization’s formal annual business plan.

E. *Communication Plan*

It is key to provide feedback on the results of this survey to your employees. You need to develop the message. – Not just what the survey said, but what the action will be coming from it. This should be done in a variety of ways:

- Intranet, mail, newsletters, email
- Managers
- Town hall sessions
- Employee focus groups, improvement teams

A Strategic, Comprehensive Approach

In addition to an employee survey, as part of a healthy workplace journey, there are a number of other elements that should be measured. NQI would be pleased to provide a suggested, progressive approach to ensure sustainability and achieve top organizational performance as well as healthy, motivated employees.

We recommend starting the NQI Progressive Excellence Program (NQI PEP[®]) for a Healthy Workplace (appendix 1)

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APPENDIX C



Healthy Workplace Initiative OH&S Inspection Report Summary

The Occupational Health and Safety (OH&S) Division of the Department of Government Services is responsible for administering Occupational Health and Safety legislation for provincially regulated workplaces. OH&S officers conduct inspections, hygiene assessments, audits and investigations routinely and in response to accidents and complaints. The following is a sampling of the numerous problem areas identified during ten years of inspection activity conducted in healthcare workplaces in Newfoundland and Labrador from 1995 – 2005 as identified from a review of Inspection / Order reports.

Storage:

- General lack of storage space for supplies and equipment
- Flammable and combustible products stored inappropriately
- Items stored near electrical panels and fire suppression equipment
- Items stored in fire exits, stairwells, corridors and other egress areas
- Inappropriate ventilation and fire alarm systems in storage areas
- Compressed gas storage rooms lacking in adequate ventilation
- Inadequate access to storage areas
- Cluttered storage areas with no clear walkway
- Files stored in area containing asbestos and mould
- High piled storage
- Improper storage of hazardous substances
- Explosive materials improperly stored

Ergonomics/Human Factors:

- Shelving and cupboards too high, too low or too deep for safe access
- Desks and computer workstations poorly configured
- Equipment too large or unsuitable for room size and shape
- Rooms difficult to access with mechanical client lifting devices
- Rooms and bathrooms too small and cluttered to work in safely
- Corridors with multiple and narrow corners and turns
- Lack of safe client handling procedures
- Excessive noise, glare and heat
- Overcrowding of the work environment

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- Injury potential created by manual beds and poorly maintained equipment
 - Laundry carts carrying excessive weight impeding safe cart movement
 - Spring loaded lifts required for laundry baskets
 - Workplace inspections failing to report on work process observations
 - Lack of soft tissue injury prevention program
 - Mops, brooms and floor cleaning procedures in need of assessment
 - Anti fatigue mats required
 - Laundry bags and garbage bags overfilled
 - New workstations requiring ergonomic assessments
 - Engineering controls required to eliminate repetitive motions and awkward postures
 - Inappropriate chairs

Design and Maintenance of the Physical Environment:

- Inadequate ventilation and temperature control
- Stairs, platforms and fire escapes with missing, damaged or insufficient rails
- Worn, damaged and slippery flooring
- Ladders and scaffolds of inappropriate design and/or construction
- Open multi-story interiors requiring fall protection
- Electrical outlets near sinks in patient rooms with no ground fault interrupters
- Doors opening outward into busy corridors
- Uncovered electrical/telephone/cable boxes
- Loading docks poorly designed and maintained
- Leaky roofs and windows causing slip hazards
- Holes in walkways, parking lots and stairways
- Light covers missing
- Worn, defective and inoperable doors and windows
- Confined spaces not identified and labeled
- Beds, lifts, chairs, carts and stretchers in need of repairs and maintenance
- Rotting roof in need of structural assessment
- Unrestricted access to roof
- Open pits and tanks unguarded
- Inadequate washroom facilities
- Toe boards required on elevated work platforms and walkways
- Damaged or missing ramps on loading docks
- Excavation site not barricaded
- Protruding nails
- Inadequate snow and ice control in parking lots
- Poorly illuminated parking lots
- Fire escapes leading to roof areas with no means of egress from roof
- Aluminum ladder used for electrical repairs

Fire and Emergency:

- Storage room partition constructed of flammable material

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- Obstructed fire alarm pull stations, fire extinguishers and fire exits
 - Compressed gases not properly secured
 - Combustible materials stored near compressed gas cylinders
 - No permit system for welding, burning and other hot work
 - Overloading of electrical outlets
 - Fire separation doors wedged open
 - Poorly maintained fire suppression equipment
 - No posted floor plan for emergency evacuations
 - Fire suppression equipment inspection dates expired
 - Items stored too close to sprinkler heads
 - Sprinkler heads non-operational
 - Flammable and combustible materials stored in ungrounded and unvented cabinets
 - Combustible materials stored in electrical rooms
 - Burned out bulbs in exit lights
 - Fire exit doors inoperable
 - Small appliances inappropriately placed creating potential fire hazard
 - Valve covers missing on compressed gas cylinders
 - Compressed gas cylinders stored under electrical panels
 - Electrical hazards caused by water leaking into electric panel and electric equipment
 - Spark arrestors and flash back arrestors required during hot work
 - Extension cords used inappropriately and without properly grounded outlets
 - Inappropriate storage containers used for flammable and explosive liquids

Mechanical:

- Missing guards on saws, conveyors, tools, pulleys, compressors, pumps, etc.
- HVAC equipment located on roofs with no means of safe access
- Emergency stopping devices missing or inoperable on equipment
- No lockout/ tag-out system
- Tripping hazards in mechanical room not marked
- Negative pressure, independent ventilation required for smoking areas

Hazardous Substances:

- Deficiencies in meeting WHMIS program requirements, including lack of:
 - General WHMIS training
 - Hazard specific training
 - Appropriate ventilation
 - Personal protective equipment
 - Labeling
 - Appropriate storage
 - Safe work procedures
 - Safer substitutes
 - Inventory of hazardous chemicals
 - Hazard communication processes
 - Emergency response plans

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- Medical surveillance
 - Risk assessment
 - Decontamination and spill procedures
 - Current Material Safety Data Sheets
 - Deficiencies in meeting requirements of Asbestos Abatement Regulations:
 - Site-specific Asbestos Management Plan
 - Hazard identification and assessments
 - Safe work procedures
 - Spill response
 - Communications and training
 - Disposal
 - Medical surveillance
 - Record keeping
 - Work permit system
 - Biological safety cabinets inappropriate or non functioning
 - Safer substitutes required for glutaraldehyde and other hazardous chemicals
 - Unlocked, unrestricted access to hazardous chemical substance storage
 - Incomplete or deficient waste management policies
 - Unsanitary washroom conditions
 - Incompatible chemicals stored together
 - Inadequate air flow, exhaust and ventilation in chemical storage areas
 - Overfilled sharps containers
 - Mould growth on ceiling tiles
 - Facility-wide hazardous materials assessments required
 - Flammable liquids stored in open containers
 - Personal dosimeters and other monitoring devices required
 - Presence of second-hand smoke
 - Sharps container selection, use and placement procedures required
 - Failure to report needlestick injuries
 - Chemical inventory to be compiled and routinely update
 - Lead assessment / management plan required
 - Lack of safe work procedures for handling, storage and disposal of hazardous waste
 - Improper storage of biomedical waste and hazardous chemical waste
 - Unlabelled containers of controlled products
 - Inadequate hand washing facilities
 - Safe work procedures required for using high level disinfectants
 - Exposure to infectious agents inadequately controlled
 - Spill containment procedures required
 - Fume hoods not working or inappropriate to control hazards
 - Fume hood ducting not properly exhausted
 - Emergency eyewash stations to be cleaned, flushed and tested regularly
 - Ventilation ductwork in need of cleaning
 - Fumes circulating through ventilation system
 - Emergency eyewash stations and emergency showers unavailable or inaccessible

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- Radiation equipment not registered
 - Radiation in excess of acceptable limits detected in occupied areas
 - Leaded door required between radiology suite and trauma room
 - Containers of hazardous substances used as door stops
 - Presence of mould and mildew
 - Fluorescent tubes disposed of inappropriately
 - Inappropriate waste handling procedures
 - Unrestricted access to biomedical waste storage areas
 - Medical waste handling standards not implemented
 - Inadequate dust control
 - Chemical management plans to be implemented.

Policy, Program and Administration:

- Development of OH&S program required
- OH&S Committees not structured or functioning in accordance with legislation
- Lack of safe work procedures and worker training
- OH&S committee meeting minutes not posted or otherwise communicated
- OH&S committee to meet within legislated time requirements
- Maintenance repair requisitions do not prioritize health and safety concerns
- Work at heights permit system required
- Safe work procedures required for elevating devices and working at heights
- Contractor safety policies not developed or not functioning as intended
- Lack of policies and safe work procedures in:
 - Confined space entry
 - Fall protection
 - Radiation safety
 - Hearing conservation
 - Client handling
 - Respiratory protection

Personal Protective Equipment:

- Lack of training in the use of personal protective equipment
- Surgical masks used to protect against volatile chemical agents
- Manufacturer's instructions re personal protective equipment not followed
- Inappropriate respirator usage due to lack of training and fit-testing
- Fall arrest safety harnesses and lanyards in need of replacement
- Eye protection needed when using caustic tub cleanser
- Hearing protection, hand protection and other ppe lacking
- Hazard assessments required to determine ppe requirements
 - Respiratory protection appropriate for the particular chemical or biological hazard
 - Respiratory protection fit-testing procedures and training to be conducted
 - Safety footwear
 - Gloves appropriate for the hazardous substance

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- Hard hats
 - Eye protection
 - High visibility garments
 - Fall arrest equipment
 - Radiation shielding devices

Communications:

- Inappropriate use of wet floor signs
- “Do Not Enter” signs missing at entrances to restricted high hazard areas
- Inappropriate mechanisms for reporting accidents
- Ineffective workplace inspection/follow-up procedures
- OH&S Committee not informed of accidents
- Progress of corrective actions not effectively monitored and communicated
- Failure to report serious accidents
- OH&S committee minutes not posted or otherwise communicated
- Inadequate or missing warning signs and hazard alerts
- Workers and managers unaware of dangers associated with hazardous substances
- Management personnel unaware of OH&S responsibilities

Training:

- Lack of training in safe work procedures
- Lack of training in safe use of equipment
- Accident and incident investigations
- Transportation of Dangerous Goods
- No training in use of fire extinguishers
- WHMIS

Other:

- Compressed oxygen used to clean dust and debris from clothes
- Insect infestations
- Health facility specific OH&S inspection checklists required
- Potential tip hazards created by improperly mounted televisions

APPENDIX D

Healthy Workplace Initiative: Creating a Culture of Safety Report of the Ergonomics Subcommittee



Ergonomics Subcommittee of the Healthy Workplace Initiative, *Creating a Culture of Safety*

1.0 The Ergonomics Subcommittee

A subcommittee of the Steering Committee was formed in order to review issues specific to ergonomics and/or soft tissue injuries in healthcare. The first challenge was setting a workable mandate given that the field of ergonomics consists of such a wide breadth of practice. It was determined that the subcommittee would not truly be an “ergonomics” subcommittee if the only issues of concern were to be soft tissue injuries. Therefore, the decision was made that the subcommittee would attempt to address the broader ergonomics issues in healthcare, one element of which is the prevention of soft tissue injuries. As a result, the subcommittee was named the HWI Ergonomics Subcommittee.

The Ergonomics Subcommittee (ES) consisted of representation from all four Regional Health Authorities, as well as WHSCC and the OHS Branch of the Department of Government Services. Members of the ES consisted of ergonomists, injury prevention coordinators, union representatives, nurses, HWI project staff and occupational therapists. The ES set out to apply an ergonomics perspective in assessing why traditional injury prevention approaches have not been fully effective in creating a culture of safety, as evidenced by high rates of injuries in the healthcare industry in Newfoundland and Labrador. The ES consisted of 13 members and one student at its greatest participation levels and was chaired by the Ergonomist at the OHS Branch of the Department of Government Services.

2.0 Committee Objectives and Outcomes:

The ES met from April 2006 until February 2007 with a total of ten meetings occurring during that time. A great deal of work was undertaken by all ES members in attempting to achieve their objectives in the short timeframe provided (12 months). The objectives were set out as follows:

2.1 Objective #1: Comparison of how ergonomics is implemented in the four Health Authorities.

The ES was able to begin substantial work on this objective, the aim of which was to research the utilization of ergonomics services among various healthcare organizations throughout the province and report on the disparity that exists in this area. The work was not published by the end of the project, however remains close to completion. Work will continue in the absence of the HWI project so that the results can be used by key stakeholders to assist in devising means of implementing ergonomics effectively across the province.

2.2 Objective #2: Recommendations for improved use of ergonomics, and for sustainability of programs related to soft tissue injury prevention.

A total of 23 recommendations have been developed through discussion with the group and other key stakeholder groups in the industry. These have been organized into three primary recommendation groups. Each recommendation and its rationale will be outlined in a final report of the ES, to be released in the months following the HWI final report.

2.3 Objective #3: Brochure outlining how ergonomics expertise can best be utilized in the health care system.

A brochure was developed and printed (with thanks to the WHSCC for printing services). This brochure outlines the definition of ergonomics and where the general principles can be identified in healthcare settings. It also includes some information on what an ergonomist is and how their expertise can be of assistance. The brochure was distributed to delegates of the Healthcare Workplace Safety Conference, as well as other groups in the healthcare system. The brochure is available to all the ES members for reprint and distribution at any time. In total, over 500 brochures were distributed throughout the province.



2.4 Objective #4: Develop a document to illustrate examples of where ergonomics principles would be beneficial for inclusion in the currently used standards and guidelines for building design.

There was a great deal of information gathered towards the development of this document which served as the basis for several of the key recommendations in the final report. They are broad, long- term recommendations with widespread implications intended to ensure that ergonomic considerations are factored into the design of new and renovated healthcare facilities since this was raised as a significant issue during HWI research. During work on this objective, there was recognition among committee members that the ergonomics community of practice is much larger than was represented on the ES and needed to include collaboration with a number of other groups such as the Department of Transportation & Works, the Department of Health and Community Services, design professionals, engineers and architects, among others. This led to a change in focus since time did not permit finalizing an ergonomics-in-design principles document. In addition, an HWI project in Interior Health in BC was found, which is dedicated to a similar, but much broader initiative. Therefore, it was determined that there was benefit in awaiting results of the initiative in BC and focusing local efforts in continuing to expand on the significant achievements that were made in improved communications among key professional groups. This was facilitated by way of teleconference meetings, workshops and the HWI Healthcare Workplace Safety Conference. Communication and collaboration that did not previously exist was begun as a result of the work on this objective and will proceed through the continued effort of members of the EC and others who are now included in this effort.

2.5 Objective #5: Information package and presentation regarding the benefits of consultation with ergonomists etc. in the design and implementation of programs, facilities etc.

An information package was developed and used extensively by the ES during the course of the project. It included a power point presentation developed for use in presentations to key stakeholder groups, an information brochure (See #2.3), a collection of pertinent research data, examples of local ergonomics deficiencies and successes, strategies from other jurisdictions, and other information relevant to the audience in each presentation.

2.6 Objective #6: A minimum of three education sessions to groups whose decisions have a direct impact on ergonomics in the healthcare environment.

A total of four presentations were made to key groups as a means of illustrating the value in incorporating ergonomics as a key component in their program, department or operation. Audiences consisted primarily of individuals who previously had little or no formal exposure to ergonomics issues in relation to their specific job functions. The aim was to make ergonomics more meaningful to these groups by providing information on how ergonomics can be used to improve their work and the overall outcomes in healthcare. Each presentation varied slightly from the other, in terms of specific issues that were pertinent at the time of the presentations.

Groups included:

- The Department of Health (primarily regarding ceiling lifts). There were two separate presentations to this group (with different representatives attending) which were both very productive.
- Purchasing groups from all four Health Authorities as well as NLHBA group purchasing.
- Facilities Management groups from all Health Authorities and government.

2.7 Other Achievements

2.7.1 Workshop:

In addition to the presentations made by the ES to the above groups, a workshop was provided on April 4, 2007 entitled: *Including Ergonomics in the Design of Healthcare Facilities*. This workshop was presented by the Association of Canadian Ergonomists, and was suggested by the ES as one of several further steps to take towards an improved overall understanding of ergonomics in healthcare. The workshop was attended by 38 delegates, with a rich representation from architects, designers, and healthcare managers and workers.



2.7.2 Ceiling Lifts

The issue of whether to install ceiling lifts in new facilities was timely during the work of the ES since this topic was the subject of debate between government and the Health Authorities. As a result, and due to the keen interest of ES members, the group made an effort to provide a service to the parties involved in this debate. A summer student was engaged to assist HWI project staff in researching this subject and a great deal of data was collected. The group was then able to bring together several key parties including private architects and other design professionals, government and healthcare (locally and from Ontario and BC) to pool resources, share the acquired knowledge and help to make well informed decisions on this matter. As a result of this effort, important decisions could be made with a better understanding of the issues around ceiling lifts and the benefits to be derived from a worker and client perspective.



2.7.3 Collaboration & Communication

The Ergonomics Subcommittee serves as a testament to the value in collaboration and communication among the Health Authorities and other stakeholder groups. The pooling of expertise among committee members resulted in the ability to achieve a great deal of work within a very short timeframe. This was assisted by the development of several key communications tools as part of the HWI project, including a website, newsletter, discussion forum, document sharing portal and coordinating secretariat services. Regular meetings and online discussions ensured that all members could actively participate in committee activities. Work on the objectives was distributed among committee members to avoid duplication of effort and to ensure optimal utilization of available expertise and resources.

Beyond the obvious increase in communications and collaboration among ES members, anecdotally it is apparent that the level of awareness and understanding of the role of human factors and ergonomics in healthcare has increased noticeably among key stakeholder groups over the past year. This is evident from feedback provided from many sources from within the Health Authorities and their partners. Examples include a request from the architect community to have their professional association represented on the ES, as well as reported changes to tendering and building design procedures being considered for implementation at the Department of Health and the Department of Transportation and Works. It is also fair to say that recognition of the broad scope and community of practice involved in the ergonomics profession is growing as a result of increased communication. This will hopefully lead to an improved understanding of the profession by the administrators whose responsibility it is to ensure that ergonomics expertise is utilized to its fullest potential in the healthcare system in Newfoundland and Labrador.

3.0 Future Plans

At this time a proposal is being produced to ask the Health Authorities for their commitment to continue the work of the ES by way of providing members of the ES the opportunity (time, funding, and resources) to continue as members of a new, re-named group which will continue to meet regularly. The mandate is yet to be developed, however it is the intention that this group will work on the initiatives started by the ES through the HWI, and to continue communications with key groups as well as to develop new plans for positive changes in the province's healthcare industry. With the anticipated support of the Health Authorities, the committee will continue under the leadership of the OHS Branch, Department of Government Services Ergonomist in the coming months.

4.0 Final Report

A detailed final report will be published in the coming months, which will provide all of the recommendations from the ES, as well as their rationale.

5.0 Ergonomics Subcommittee Membership

Organizations represented on the HWI Ergonomics Subcommittee include:

Eastern Health Authority

Central Health Authority

Western Health Authority

Labrador/Grenfell Health Authority

Workplace Health, Safety and Compensation Commission

Healthy Workplace Initiative project

Department of Government Services, OHS Branch

For more information on the Ergonomics Subcommittee or its work, please contact:

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APPENDIX E

Final Report – Creating a Culture of Safety

Evaluation: Healthy Workplace Initiative Immediate Outcome Measures

Stakeholder Focus Group Findings

Focus groups with key stakeholder groups were conducted as part of an evaluation study of the success of the Creating a Culture of Safety project funded through the Health Workplace Initiative of Health Canada. Three separate focus groups were conducted with government representative, regional health authority representatives, and union representatives. The government representative focus group consisted of four respondents (N = 4) from the Department of Health & Community Services, Workplace Health Safety & Compensation Commission, Newfoundland and Labrador Health Boards Association, and Department of Government Services. The regional representative focus group included seven representatives (N = 7) from the following regional health authorities: 2 from Western Health, 1 from Labrador-Grenfell Health, 2 from Central Health, and 2 from Eastern Health. The union representative focus group consisted of 2 respondents from the Newfoundland Association of Public Employees and the Newfoundland and Labrador Nurses Union. The focus group script is presented in Appendix A.

Raising Awareness

Focus group respondents were asked to discuss the success of the project in raising awareness amongst health care organizations at all levels and stakeholders of healthy workplace initiatives/practices. Several common themes emerged amongst respondents when commenting on the level of awareness brought on by the project. Respondents from the three focus groups commented on the development of the ‘Newsletter’ and ‘Website’ as positively contributing to the awareness of healthy workplace initiatives.

“There’s been a web page developed that’s been communicated to staff, to Occupational Health and Safety Committees, and there was also a newsletter. It’s been available to all staff electronically, and that’s certainly raised awareness. It’s well identified as a Culture of Safety Project or its part of that.”
(Regional rep.)

“The newsletter has generated some actions. It has created some basic understanding. It has been circulated to all employees in the dept. causing some change in peoples’ frame of mind. Government Services has jumped on this, dealing with facility design, ergonomic issues...” (Gov’t rep.)

“The newsletter was positive in getting information out to all employees. The website was another tool used which did raise awareness.” (Union rep.)

Respondents from the government and regional focus groups also commented on the upcoming Workplace Health and Safety Conference being planned for April 2007 as another initiative that is raising awareness.

“The Workplace Health and Safety Conference, which is coming up now the second of April... what’s going to happen there is findings will be presented from the Healthy Workplace Initiative, and it will provide opportunity for, you know, health care workers and other people around the province to network and they’ll certainly learn about the latest trends in health care and safety.” (Regional rep.)

The government and regional focus group respondents also commented positively on how the meetings and working groups have contributed to the level of awareness.

“...the mere getting together with a collaborative approach of a steering committee coming together from all different levels – even that in and of itself has created awareness, and people at all levels talking about safety.” (Regional rep.)

“Meeting of stakeholders has generated discussions at higher levels of management i.e. VPs and ADMs. The development of working groups has generated awareness.” (Gov’t rep.)

The union representatives commented that although there has been collaboration, it has been a challenge trying to filter information down to the frontline workers. A comment was made that this has only raised awareness for the employers. It has not gone down through management to the employees.

“I can’t say that it’s raised any awareness from a union perspective that I’m aware of. I can say that it’s certainly awareness for the employers but how that has equated to awareness among the employees employed in that workplace, I’m not sure.” (Union rep.)

A regional health authority respondent also identified the focus groups which had been conducted at the beginning of the project as an important activity of the project which has raised awareness as well as the *“Ergonomic Forum that was developed for dealing with ergonomic issues has been really beneficial. It has been used quite frequently.”*

“One thing that’s brought some attention has been the focus groups ... the across-the-province kind of tour. They went to most of the sites and offered focus group sessions and, not just in the major centres, but also outside in some of the more rural areas. It helped certainly create awareness.” (Regional rep.)

Influence on Commitment

Focus group respondents were also asked to describe how the project influenced the level of commitment (e.g. new funding, greater resources, greater attention to healthy workplaces) for healthy workplace initiatives/practices that impacted front line workers. The common theme among all focus groups was the incorporation of new technologies and equipment into facility design and development. Respondents across all three groups agreed that the collaboration resulting from the healthy workplace initiative has allowed groups of people to work together in the design of new facilities and the incorporation of health and safety equipment and devices in the workplace that never would have necessarily been brought together before.

“GB Cross Memorial Hospital is building a new wing, and they’re going to be installing the latest of equipment that was discovered as a result of this project that is available out in industry that will make work for LPN’s and nurses and people in health care a lot easier.” (Union rep.)

“It’s also influenced, our new buildings and the design of the new buildings and are there things that we can put into our new buildings that will make it safer for our staff and, ultimately, you know, the clients, residents, and patients that we serve. So there have been examples of that – like lobbying for ceiling lifts and those types of things in some of our facilities.” (Regional rep.)

“...there’s been some discussion regarding the ceiling lifts, and that came directly from the project, I understand the Department of Health or government – is going in that direction with regard to new facilities...” (Gov’t rep.)

Respondents from the government and regional health authority focus groups also commented on factors related to the budgetary process which affects the level of commitment. This was described as a ‘wait and see’ process when things are put through for budgetary consideration. Hopefully, with this raised awareness health and wellness issues will be given new priority. Union representatives commented on the lack of funding and therefore a lack of commitment.

“Things are being put through the budgetary process, we’ll have to wait and see from this what level of commitment is there. It has forced the question.” (Gov’t rep.)

“In the number of budget exercises that I have been involved in now, we’re more inclined to say anything that has safety and workplace health involved moves to the top of the list.” (Regional rep.)

“We need to see resources, funding and human resources. ...not seeing that level of commitment from government.” (Union rep.)

Collaboration was also mentioned as a factor influencing the level of commitment by both government and regional representatives.

“We have people agreeing to be on the steering committee, so that has shown an improvement in the level of commitment.” (Gov’t rep.)

“There’s been collaboration with social workers and the ARNNL on their forums ...they are holding panel discussions on violence in the workplace.” (Regional rep.)

Representatives from each group felt that the project influenced the level of commitment by changing peoples’ views and allowing these views to become more apparent.

“I think it certainly has influenced the level of commitment. It has caused people to think about a healthy workplace and value the people that work in our organization, and I also think that that’s happened throughout all levels of the organization.” (Regional rep.)

It has highlighted peoples’ positions. It’s a question of process and approach. In the dept level there is good commitment.” (Gov’t rep.)

“It has helped to focus on what has been done and what is working, it has helped focus people back again to the issues, away from the ad hoc approach that has been taken.” (Union rep.)

Influence on Government Policy/Programs

Focus group respondents were asked to comment on how the project has influenced healthy workplace initiatives/practices at a governmental policy/program level. Respondents from both government and regional health authority focus groups described the work being done with the ceiling lift project as having an influence on government policy. It is influencing the design of new facilities and the direction policies concerning facility management are going. A lot of work has also been done around Ergonomics. These are all things now being incorporated into new facility designs.

“In terms of the policy and program level, the specific answer... the specific example I can think of is around the design of our facilities and influencing that policy direction. The facility design piece was the one... and the ceiling lift project and the presentations that were done through the Department of Health & Community Services.” (Regional rep.)

“In Government Services, quite significantly, there has been a huge influence. The ceiling lifts and ergonomic work being done, incorporating all these things into the facility design piece.” (Gov’t rep.)

Respondents from these two groups also felt it was too early to see the impact on government policy and front line workers.

“Impact on front line workers is still too early to tell. There has been good impact on discussions around the table, but we need time to have this filter down to the front line workers.” (Gov’t rep.)

“I think it’s really difficult to... for us to say whether or not it’s made any impact on government. It’ll take a little bit of time before we really see how much influence it’s had on government. The kind of work that the project is working towards is valuable; but it’s a relatively short duration so far and we’re not even 18 months yet.” (Regional rep.)

Respondents from the union focus group felt that there was very little evidence of any impact on government policy. They commented on the possibility that the final report will hopefully drive all stakeholders to do more. They are hopeful that it may be used as a tool to help affect change.

“I don’t think that government has been impacted at all. ...they’ll listen to what you’ve got to say but the likelihood they’re going to change anything they’re doing as a result of it is pretty slim.” (Union rep.)

“The level of involvement by government has been limited, needs to be more liaison with government, more hands on.” (Union rep.)

Influence on Organizational Policy/Programs

Respondents were asked to discuss how the project has influenced healthy workplace initiatives/practices at an organizational policy/program level. Respondents from the regional health authority and union focus groups felt that the process of collaboration had fostered the most significant influence on organizational policy/programs. The project has brought people together to create a collective voice. It has helped to develop new OH&S committees. It has allowed groups to identify similar priorities, and through collaboration and knowledge sharing developed a clearinghouse for information.

“...be able to collaborate with other people who are in... you know, in the same... same phases of development with OH&S and to be able to communicate and identify our similar priorities.” (Regional rep.)

“There’s a lot of value of having that collective voice looking and bringing a number of different experts together across the province to collectively have that discussion.” (Regional rep.)

“...the subgroups getting together and influencing decision makers. A lot of work has gone into the overhead lift project and Ergonomics. They developed a forum where they could collaborate.” (Union rep.)

Respondents from the union focus group felt that organizations are more aware of their unique health care issues and that funding these initiatives has value.

“...they’re certainly more acutely aware that health care in and of itself had issues that could be labeled unique to them, and I do believe that they see value in supporting some form of continued funding, I think, from an organizational perspective from health care...” (Union rep.)

Government respondents perceived less direct influence on organizational policy/programs. The ceiling lift project was mentioned as an example of success that will benefit workers in the regions. It was felt that more time was needed to identify gaps and the resources to fill these gaps. There may be some greater awareness at the senior levels, but it hasn’t filtered down to frontline workers yet.

“Don’t think there has been much yet. Need to look at what has been holding us back, where the holes are. Hopefully the final report will help to do that and identify the resources needed to fill those gaps. The ceiling lift project is an example of a success. The more the regions have the better things will be for the front line workers.” (Gov’t rep.)

“...it’s created a greater awareness with some of the... I guess... the senior levels, I guess, what I’m saying but I’m not sure how much has actually filtered down.” (Gov’t rep.)

Fostering Collaboration

Respondents were asked to describe how the project fostered collaboration between different stakeholder groups with respect to healthy workplace practices. Respondents from regional health authorities felt that the project had created a strong network across the province. It has brought people together that otherwise may not have collaborated. They commented that the relationship between union and management was strengthened with respect to addressing health and safety issues and concerns. The collaboration between government and the regions is better now than it was before the project was initiated.

“...the project has shown that it’s possible to have different types of collaboration than were in place before. The project has demonstrated that it is possible for union and management to get around a table and discuss, you know, a project like this meaningfully and put aside the union hats and the employer hats.” (Regional rep.)

“One of the biggest and most tangible things to come out so far, just being able to involve government - the Department of Health & Community Services and the Department of Transportation and Works - in that discussion, along with purchasing personnel, but also to draw in the architects and engineers and planners who are the ones who are designing the facilities, and I guess to engage them in the concept of health and safety. I think that’s something that can go a long way and demonstrates a level of collaboration that we didn’t have before.” (Regional rep.)

Government respondents felt there was great potential for further collaboration. They felt it has brought the stakeholders together and different professions together.

“The potential is there, some past approaches have caused people to dig in on their own positions. There are currently a lot of unresolved questions.” (Gov’t rep.)

“And from the hands-on kind of levels – again, I’m talking about the specifics here with the Ergonomics group – that there’s new liaisons created there that weren’t there before with different stakeholder groups. Now it could prove in the future to be pretty valuable for healthy workplaces.” (Gov’t rep.)

The union representatives commented on the fact that the steering committee was a large group and at times various players were missing from the table. They also felt that communication could have been better.

“...didn’t have very many face-to-face meetings, some issues were not fully expressed that might have been at face-to-face meetings. Having the right people at the table is also important. You need the right people there, who can make decisions and take information back to their organizations.” (Union rep.)

Impact on Front Line Workers

Overall, respondents were asked to identify and describe the overall impact of the project on frontline workers. Respondents from all three groups felt it was too early to see any overall impact of the project on frontline workers. Overall awareness may have been raised on some issues.

“Right now, I don’t think there’s been a direct impact, but I do believe that the work that they’ve started is certainly going to play a role in how health care looks at health and safety in the future.” (Union rep.)

“Minimal impact so far, the project is not finished yet.” (Gov’t rep.)

“...it’s a really early question...only now getting to the point where they’re able to give us feedback on what our state of existence is, I suppose; but it’s

difficult to see the direct impact at the frontline worker level at this point.”
(Regional rep.)

“I don’t think there’s been much impact to this point in time; and, again, it’s the duration of the project. I think it’s planted some seeds but who knows what the outcome is going to be.” (Gov’t rep.)

Significant Outcomes

Respondents from all three focus groups felt that the most significant outcome of the project was creating awareness around healthy workplace issues. Some consultation and education has been conducted. It has made people more aware that safety is a cost driver in health care and a significant threat to workers.

“...it has started some dialogue between people who are interested in putting workplace safety on the radar.” (Union rep)

“It has put the issue on the table and generated a lot of awareness. We are more aware of differences in opinion.” (Gov’t rep.)

“Helping to understand some of the common issues that exist across all provincial organizations.” (Regional rep.)

Regional health authority and government respondents commented on several other significant outcomes from the project. Engaging government and change champions were felt to be two of the more significant outcomes. These representatives also commented on the development of communication tools as an outcome of the project.

“Engaging the Department of Health on a design level and on a health and safety level is going to be lasting outcome. The work that the Ergonomists have done in the ceiling lift project is going to have a very big impact on frontline workers, and they’re going to really see that, hopefully, this was something lasting that came out of that project.” (Regional rep.)

“There’s a whole group of change champions that want to do something with safety in the workplace and I think that’s a significant outcome, regardless of what happens.” (Regional rep.)

“We do have these communication tools now as well – the forum, the website, and those are things that all of our committees, all of our frontline workers can use to discuss and to research safety issues.” (Regional rep.)

“...the fact that government is looking at the ceiling lift is a major outcome because I think that’s been an issue that’s been talked about for years and hasn’t really caught anybody’s attention. It seems now to have at least stuck somewhere

that government is looking at that for future capital projects more or less. So that's a major thing." (Gov't rep.)

Government representatives also felt that a significant outcome was the advancement of Ergonomics in the workplace and the development of the Ergonomic sub-committee.

"Ergonomic sub-committee is likely to just go on anyway. It's something that's created by the program or the initiative, but it's likely to continue on its own, and that creates a lot of good work too if everybody are working together because it's from all the boards." (Gov't rep.)

Significant Changes

The representatives commented that awareness of the issues around workplace safety was the most significant change since the project started. It has created a resource and allowed people to look at the issues from a provincial level.

"It is making people sitting on the committee aware that they should be doing more. It is starting to change the safety culture in health care. It has started a dialogue and built relationships with people working toward the same objectives." (Union rep.)

"Now have a provincial resource in place. There was a need for some sort of mechanism to be in place to provide for the ground work that needs to be done. It is allowing for people to look at the issue at a provincial level." (Gov't rep.)

"...the Ergonomists and people dealing with Ergonomics before were kind of sending each other an e-mail here or there or trying to grab someone when they could get a chance, whereas now there's a consistent format and a consistent group of people that they go to, to ask questions and find out where to go for more information and stuff. So their job and information searches might be a little bit easier, and that's different..." (Gov't rep.)

Sustainability

Respondents were finally asked to discuss what needed to be done to sustain and carry on with the work resulting from the *Creating a Culture of Safety* project. Respondents from both the union and government focus groups commented that there was a need for further funding to sustain the work resulting from this project.

"Need to have some provincial stakeholders put some seed money on the table in order to establish a long term mechanism, to propose something solid. This needs to be done as soon as possible or the momentum will be lost. (Gov't rep.)

The government and union representatives also felt that there needs to be a force behind the initiative and that resources and leadership should be centralized.

“An issue of this magnitude requires centralized resources. There is a need for leadership at the provincial level – coming from Worker’s Compensation and the Department of Health & Community Services.” (Gov’t rep.)

“There needs to be a dedicated resource whose mandate is to affect change down the line, to coordinate with the Health Authorities and act as a clearinghouse for information.” (Union rep.)

“I think there needs to be some collaboration from the major stakeholders to really work towards developing a body that will continue to work that’s not temporarily developed – like an actual permanent group of people that will deal with this kind of stuff.” (Gov’t rep.)

The regional representatives commented on the need for a strategic plan, and an ongoing collaborative approach to help sustain the work resulting from the project thus far.

“...the final report is something really concrete that we can sink our teeth in, hopefully, and lead us to where we need to go. Hopefully, that will form the basis of some sort of a strategic plan forward.” (Regional rep.)

“A collaborative approach again between health care representatives, unions, industry representatives...” (Regional rep.)

Appendix A: Stakeholder Focus Group Script

Healthy Workplace Initiative

Stakeholder Focus Group Questions

Thank you for agreeing to participate in this Focus Group discussion. This Focus Group is part of an evaluation study of the success of the **Creating a Culture of Safety** project funded through the Health Workplace Initiative of Health Canada. The overall purpose of the **Creating a Culture of Safety** project was to create an enhanced culture of safety in all Regional Integrated Health Authorities in Newfoundland and Labrador. Your opinions are highly valued and appreciated and will contribute to the evaluation of this project.

Please start by introducing yourself.

1. How successful has the **Creating a Culture of Safety** project been in raising awareness amongst health care organizations at all levels and stakeholders of healthy workplace initiatives/practices?
 - What specific project activities were most successful in creating this awareness?
2. How has the **Creating a Culture of Safety** project influenced the level of commitment (e.g. new funding, greater resources, greater attention to healthy workplaces) for healthy workplace initiatives/practices that impact front line workers?
 - What are specific examples?
3. How has the **Creating a Culture of Safety** project influenced healthy workplace initiatives/practices at a *governmental policy/program level*?
 - What are specific examples?
 - What impact has or will this have on healthy workplace initiatives/practices that impact front line workers?
4. How has the **Creating a Culture of Safety** project influenced healthy workplace initiatives/practices at an *organizational policy/program level*? (e.g. Regional Health Authority, institutional)
 - What are specific examples?
 - What impact has or will this have on healthy workplace initiatives/practices that impact front line workers?
5. How has the **Creating a Culture of Safety** project fostered collaboration between different stakeholder groups with respect to healthy workplace practices?
 - How successful has this been?
6. What has been the overall impact of the **Creating a Culture of Safety** project on frontline workers?

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7. What have been the most significant outcomes from the **Creating a Culture of Safety** project?
 8. What is different **NOW** versus **BEFORE** this initiative began?
 9. What needs to be done now to sustain and carry on with the work resulting from the **Creating a Culture of Safety** project?