

SASKATCHEWAN INSTITUTE OF HEALTH LEADERSHIP

“SAFE WORKERS IN A SAFE WORKPLACE”

SAFETY JUNKIE’S GROUP PROJECT

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Project Summary:

The Ministry of Health has developed a Strategic Plan for improving health care in Saskatchewan. One of the key targets addresses employee safety, with the intent to achieve a goal of zero workplace injuries by March 31, 2017. Our group felt that one of the major ways to reduce workplace injury in health care would be to ensure employees receive adequate training to safely engage in their duties. We sought to address this key contributor to employee safety by focusing on training and safety programs for nursing staff in health care. For this reason, we performed an environmental scan within our three health regions, from both urban and rural perspectives.

Based on the information we obtained, some potential difficulties of the current system became apparent. Our aim was to provide an outline of some of these challenges as well as to contribute suggestions for potentially improving the process. By describing the historical and current states of nursing training programs, acknowledging the work currently being done and recognizing the opportunities for future improvement, we provided a perspective “from the front line”. It was our hope that this overview would contribute to the improvement of employee safety within Saskatchewan health care.

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We would also like to extend our appreciation to the numerous people within our health regions who provided insights, answered questions and reviewed our report to enhance accuracy and completeness.

Finally, we would like to thank everyone involved with the Saskatchewan Institute of Health Leadership for facilitating our engagement in this project and for helping to make it such a positive experience.

“Safe Workers in a Safe Workplace”

I. Introduction to the Safety Hoshin

The Ministry of Health has presented a five-year strategic plan in which they have committed themselves to improving the health care system in a way that provides “Better Health, Better Care, Better Value and Better Teams”. The first year, 2012-13, was a planning year. The strategic plan, referred to as the “Hoshin Kanri”, includes numerous five-year outcomes, improvement targets and current initiatives aimed at achieving one of each of the four strategies.

The fourth strategy, *Better Teams*, includes the development of safe, supportive and quality workplaces with which to provide patient-centered care. This Hoshin has been branded the “Culture of Safety”, and the goal is to bring about a cultural shift for how things are done in health care. As with all system Hoshins, there is a several year plan with defined deliverables each year. The key Hoshin target is to achieve the goal of, “zero workplace injuries, by March 31, 2017,” as measured by the number of lost time and non-lost time Worker’s Compensation Board (WCB) claims per 100 Full-Time Equivalent (FTEs).¹

Hoshin Target Measures

Utilizing 5500 injuries in 2011-12 as the starting point:

- Reduction in 2012-13 - 20% (no more than 4400 workplace injuries)
- Reduction in 2013-14 – 25% (no more than 3300 workplace injuries)
- Reduction in 2014-15 – 40% (no more than 1980 workplace injuries)
- Reduction in 2015-16 – 50% (no more than 990 workplace injuries)
- Reduction in 2016-17 – 75% (no more than 248 workplace injuries)
- March 31, 2017 and forward – zero workplace injuries

One of the deliverable steps includes tracking of 100% of the level 1 and 2 safety training received by the Occupational Health and Safety Committee Chairs and Co-Chairs. This action allows for the development of high functioning Occupational Health and Safety (OH&S) teams at local levels that can act as catalysts for change. A key system lagging measure is to see a 20% reduction in WCB injuries in the first measuring year. In a true top down fashion, the training for supervisor's process is an important lead out. This approach is anticipated to allow for the building of a cultural shift in the approach to a safe work place.

In a letter sent out to Saskatchewan employers in April 2012, Glennis Bihun (Executive Director of OH&S), on behalf of the Ministry of Labour Relations and Workplace Safety (LRWS), stated that, "...the WCB published the 2011 lost-time loss injury rate at 3.05 per cent. While this is a 2.2 percent decrease over 2010, and there has been a 38 percent decrease from the province's twenty-year high in 2002, this rate, along with the total injury rate, which rose 0.03 percent from its 2010 level to 8.73 percent, remains unacceptable. Saskatchewan continues to have the second highest injury rate in Canada.²" These statistics and the priorities set out by the Ministry of Health support the importance of reviewing the state of employee safety in healthcare.

II. Project Scope Statement

The five members of our team came together to address the Hoshin of employee safety by providing an environmental scan of the historical and current safety training approaches provided to workers in the reviewed regions. The team was comprised of representation from the Saskatoon Health Region (both rural and urban), Sun Country Health Region and Five Hills Health Region along with a Ministry of Health member. Information from the environmental scan was collected beginning November 2012 and continuing until the end of February 2013. While the scan included information from the represented health regions, it did not address the work on this topic in all regions. The group did feel that they had a sufficient mix which could be viewed as likely representative of the broader provincial picture.

Given the large and diverse range of care providers within health care, the group felt that the first step in addressing employee safety was to focus in and target those involved in hands-on patient care activities. For this reason, the main employee groups involved in the scan were Registered Nurses (RNs), Registered Psychiatric Nurses (RPNs), Licensed Practical Nurses (LPNs), Special Care Aides (SCAs) and Continuing Care Assistants (CCAs). There was particular focus on specific training programs including Gentle Persuasive Approach (GPA), Transferring, Lifting, Repositioning (TLR), Professional Assault Response Training (PART) and Workplace Assessment and Violence Education (WAVE).

With the scan of the past and present activity, the group aspired to provide insight to the system of how the current training activities and reporting could impact the meeting of deliverable targets for the Hoshin. Through this work there was also the opportunity to identify where the Hoshin work has made positive impacts and connect the system to areas that could potentially benefit from further focus.

III. Definitions

1. Involved Organizations

a) Occupational Health & Safety (OH&S)

Occupational Health and Safety is a cross-disciplinary area concerned with protecting the safety, health and welfare of people engaged in work or employment. It involves interactions among many subject areas, including occupational medicine, occupational hygiene, public health, safety engineering, industrial engineering, chemistry, health physics, ergonomics and occupational health psychology. The goal of the OH&S programs include fostering a safe and healthy work environment for employees and may also protect co-workers, family members, employers, customers, and others who may be potentially affected by the workplace environment. All organizations have a duty of care to ensure that employees and any other person who may be affected by the company's undertakings remain safe at all times.

The Saskatchewan Occupational Health and Safety Act defines OH&S as⁵:

- (i) the promotion and maintenance of the highest degree of physical, mental and social well-being of workers;
- (ii) the prevention among workers of ill health caused by their working conditions;
- (iii) the protection of workers in their employment from factors adverse to their health;
- (iv) the placing and maintenance of workers in working environments that are adapted to their individual physiological and psychological conditions; and
- (v) the promotion and maintenance of a working environment that is free of harassment.

OH&S focuses not only on the maintenance of workers' health, but also on the improvement of the working environment and the development of work organizations and working cultures in a way that supports health and safety at work. The concept of working culture is intended to reflect the value systems adopted by those involved, and be supported by the practices of the managerial systems, personnel policy, principles for participation and training policies of the employer. OH&S is important for moral and legal reasons. Moral obligations involve the protection of employee's lives and health. Legal reasons for OH&S practices relate to the preventative, punitive and compensatory effects of laws that protect worker's safety and health. Ultimately, the engagement of OH&S is anticipated to reduce employee injury and illness related costs, including medical care, sick leave and disability benefit costs.

Recently the Labor Relations and Workplace Safety (LRWS) Division established legislation giving authority for OH&S Officers to issue summary offence tickets (SOTs). Employers, contractors, owners, suppliers, self-employed persons, supervisors and workers can all be ticketed under this system for failure to comply with the OH&S Act and Regulations. When Occupational Health Officers identify an instance of non-compliance on a ticket-able offence, an SOT may be issued. To determine who will receive the SOTs, officers will apply the principles of the workplace responsibility system to consider those who have the greatest degree of control over the workplace as having the greatest responsibility for providing a healthy and safe workplace.

The SOTs may be applied to high volume offences that reflect an on-going history and pattern of non-compliance, those offences that are frequently recommended for prosecution by the OH&S Division as well as offences where non-compliance has a high risk of injury, illness, or death. There are a total of 71 offences covering 38 sections of the OH&S Act and Regulations. Some SOT examples applicable to health care include failure to wear personal protective equipment, and improper lifting of patients.⁵

The system measures which track the improvement in the OH&S culture include those associated with the “Culture of Safety” Hoshin.

Leading Metrics Associated with the Culture of Safety for OH&S

- % Occupational Health and Safety Committee Training Level 1 – Co-chairs
- % Occupational Health and Safety Committee Training Level 1 – Committee Members
- % Occupational Health and Safety Committee Training Level 2 – Co-chairs
- % Occupational Health and Safety Committee Training Level 2 – Committee Members
- % Occupational Health and Safety Committee meetings - at least quarterly with quorum
- % Completion of Action Plan arising from completed Self-Assessment of March, 2013

b) *Saskatchewan Association of Safe Workplaces in Health (SASWH)*

The Saskatchewan Association of Safe Workplaces in Health was founded on February 12, 2010. This organization represents the overarching safety group for all of the health care industry. Their stated mission is, “To increase awareness and proactively support, through education, training and services, health related industry workers and employers in their efforts to prevent workplace injury and illness⁵” and their vision is, “Workplace health and safety: a priority for all⁵”.

In 2011, SASWH’s “Six Strategic Priorities” were to⁵:

- i. Promote the establishment of strong accountability frameworks for OH&S within health sector workplaces.
- ii. Promote the recognition of the value that injury and illness prevention brings to the workplace.
- iii. Establish the SASWH as a credible source of OH&S information and services for members.
- iv. Promote the adoption of evidenced-based leading practices and provincial OH&S standards within health sector workplaces.
- v. Provide training and education that supports injury and illness prevention.
- vi. To demonstrate transparency and accountability in the association’s resource allocation.

In line with the government’s Hoshin, SASWH states that they are committed to reducing the number of workplace injuries and illnesses in the health sector and that they have a three year target of, “A reduction in total and time loss injury rates within the health sector by the end of 2013⁶”. They state that the goal is to “work with their members to reduce injuries in the healthcare industry in line with Hoshin reporting targets⁶”.

Previously, SEIU-West had met with the former CEO of SASWH, George Marshall, who stated that given the high incidence of workplace injury in Saskatchewan Health Care, SASWH’s top priority was to change the culture of safety to one which values safety foremost.

To do this, they identified the following three key factors which they believed needed to change⁷:

- i. Leadership - Employers have to equate worker safety to resident/patient/client safety. They have to view safety as an investment and they have to recognize that prevention strategies are necessary if we are to move forward. Unions must also reinforce their commitment to safety and invest in training and encourage union members to think of their safety first. Unions/stewards/workers need to support their members when they come forward with safety issues and encourage them to report all injuries.
- ii. Accountability - Employers are required by legislation to have OH&S committees. There needs to be support and training offered to ensure these committees function properly. The root cause of incidents and accidents need to be determined for all workplace incidents and prevention rather than blame needs to be a focus for committees in the resolve of the incident report.
- iii. Systems – Systems need to be in place to ensure health and safety in the workplace; this includes proper training, orientation, safety procedures, prevention strategies, effective communication, accurate reporting, access to proper safety equipment, root cause analysis, as well as functioning OH&S Committees among the many other components.

Programs offered by SASWH include Safety Management Systems, a Safety Management System Self-Assessment Education Course, Effective Occupational Health Committees in Health Care, Leadership and Safety, as well as Risk-based Training Programs.

The SASWH Strategic Plan notes that the health sector has a higher workplace injury rate than any other industry in Saskatchewan, and that there was an increase in health sector total injury rates from 11.57% in 2003 to 13.06% in 2009⁵. More recently, statistics indicate that the health sector total injury rate was 12.21% in 2012⁸. Over the past 5 years, Health Care has lost nearly half a million working days which is equivalent to 2400 workers being off for 1 year⁶.

Of note, at the outset of the project, the group had difficulties in overcoming barriers in communication with members of SASWH. This initially made it difficult to determine the exact role of SASWH as an advocate for staff safety from the floor perspective.

2. *Relevant Risk-Based Training Programs*

There are various training programs available in Saskatchewan which provide differing amounts and varying levels of education to health-care workers depending on their job description and degree of direct patient care. The province has stated that a safety program for the transfer of patients and objects, a violence training program and respirator fit testing are mandatory for all staff. The programs described below are available for employees, from front-line staff to supervisors to managers. The following provides a brief description of some of these key programs which are available:

- a) *Gentle Persuasive Approach (GPA)*^{9,10} - Gentle Persuasive Approach (GPA) in Dementia Care, is an innovative education curriculum that is currently being offered to care organizations throughout Canada, and which began being rolled out in Saskatchewan in 2011. Across Canada, more than 90,000 staff members have been trained in Gentle Persuasive Approach by over 1250 GPA Certified coaches. We do currently have GPA Certified Coaches in Saskatchewan.

Training with GPA promotes behavioral management principles and ensures that healthcare employees who work with older persons are trained with practical tools, principles and resources to deal with difficult situations. The training allows staff to respond professionally and with resiliency to aggressive behaviors which may be exhibited by people living with dementia. The program asserts that assisting healthcare staff in developing confidence in their ability to provide compassionate, safe care during responsive and aggressive episodes is a necessary aspect of professional competence and contributes to the development of a stable and sustainable healthcare workforce.

Specifically, Gentle Persuasive Approach's curriculum develops skills which allow participants to achieve the following module goals:

- 1) Gain understanding that each person with dementia is a unique human being who is capable of interacting with the outside world.
- 2) Explore a holistic perspective to explain the relationship between the disease process and the person's behavioral response.
- 3) Apply emotional, environmental, and interpersonal communication strategies that diffuse challenging behaviors.

- 4) Respond with the suitable and respectful protective techniques to use in response to catastrophic behavior.

GPA is targeted to all levels of staff and departments in care organizations who work with older adults. Involvement in this curriculum provides staff with the opportunity to develop skills to manage difficult behaviors they are confronted with in an effective manner. The overall goal of the GPA curriculum is to educate employees on how to use a person-centered, compassionate and gentle persuasive approach and to respond respectfully, skillfully and confidently to challenging behaviors associated with dementia.

- b) Transferring, Lifting, Repositioning (TLR)*¹¹ – This program is utilized to educate staff on how to use proper body mechanics and protect or eliminate the risk of musculoskeletal injuries related to patient handling. The goal of TLR is to assist with reducing and/or eliminating worker injuries associated with moving both clients and objects. TLR is intended to provide alternate methods to manually move loads in all health care activities. Workers involved in client handling receive training in TLR Client Moving, while workers involved in materials handling receive TLR Object Moving training.

To achieve success, healthcare must be dedicated to change and willing to accept the critical components of TLR which include adequate and ongoing training, proper and sufficient equipment, and policies and procedures to ensure consistent application of the TLR principles. TLR provides information to assist employees with completing an assessment to identify risks, determining ways to manage or eliminate the risks and in selecting an appropriate moving technique at the time of a move. The goal is to achieve minimal use of manual effort with maximum use of equipment to minimize and prevent risk associated with moving patients and other objects.

TLR recertification is required every three years for a minimum of 4 hours training. TLR Object Moving will replace Safe Moves, and is also required to be recertified every three years. TLR training is now under SASWH, however they do not enforce recertification, but rather they provide guidance to managers. To achieve compliance and optimize accountability, the employer must provide the training and the equipment. Managers must ensure employees are recertified or reevaluated on an ongoing basis, and

employees must ensure they use their training skills and the equipment appropriately. Everyone is expected to report all incidents which do occur.

c) ***Professional Assault Response Training (PART)***¹² – Professional Assault Response Training (PART) is an in-service workshop for professionals who work with individuals whose disabilities may manifest in assault. The author, Dr Paul Smith, developed the first version of PART in 1975 while he was working as a Licensed Psychiatric Technician in California. The purpose of the course was to provide the psychiatric nursing staff with manual restraint methods which provided adequate control of the individual's limbs, and had the minimum risk of injury to the individual and staff. It became apparent that there was not enough teaching on how to minimize the behavior that was causing the aggression, so the PART program was rewritten in 1982 with more emphasis on self-control, assessment skills and verbal crisis intervention. It was revised in 1992 with results from participant feedback and the diligent work of Professional Growth Facilitators. The revisions brought the written workshops up to date. In 2007, SAHO purchased the copyright of the program from Dr. Paul Smith, and many of the provincial instructors of PART were taught by Dr. Paul Smith in Saskatoon at that time.

PART represents an approach rather than an array of techniques. Principles are emphasized rather than specific interventions. The primary purpose of the course is to help participants ask the right questions so that they can solve problems for themselves. It is designed to provide adequate thinking and movement skills to enable women and men of equal strength and abilities to remain safe in the workplace. The training maintains a dual focus on individual/worker safety and the individual/worker rights.

d) ***Workplace Assessment and Violence Education (WAVE)***¹³ – WAVE was developed in 2010 by a safety consultant and clinical educator in the Saskatoon Health Region. The program focuses on the care of violent and aggressive patients, including those with Alzheimer's and dementia, with the training utilizing role playing and emphasizing prevention. It is geared 90% towards prevention and 10% towards reaction. WAVE teaches employees how to approach a person while conducting an assessment in order to determine whether or not it is safe approach. In keeping respect and safety foremost, appropriate ways to manage unique situations are discussed and

practiced. The program provides support to the employee by reviewing “stay safe” measures which may be practiced both in an individual’s personal life as well as in the workplace. It is felt that applying these methods in these areas will strengthen workplace violence prevention.

- e) ***Respirator Fit Testing***¹⁴ - Beginning in 2009, mandatory N95 Respirator Fit Testing for all employees was initiated through OH&S. In situations where an employee may be exposed to airborne contaminants and where there is potential for significant harm to the worker (e.g., tuberculosis, pandemic influenza), the employee must be fit tested prior to use of a respirator to ensure proper fit and proper donning of the respirator. N95 respirators are tested by a trained person to evaluate and ensure the fit of a respirator on an employee.

IV. Environmental Scan of the Health Regions - Historical and Current Approach

1. Five Hills Health Region (FHHR)

The Five Hills Health Region (excluding St. Joseph’s Hospital and Extendicare) has a monthly general orientation for all new hires in the region which is mandatory prior to starting their position. Since the year 2000, all employees have been trained in TLR Object Moving since, and most have also been trained in PART Basic since 2007. Beginning in September 2012, those hired to Providence Place (a long-term care facility in Moose Jaw, which includes a geriatric assessment rehabilitation unit, Alzheimer’s unit and day program with a focus on elder care), are instead trained in GPA. TLR Client Moving is provided for those who will be doing any patient moving or assisting, while PART Intermediate and/or Advanced is provided for staff in high risk areas for injury (e.g., psychiatry). All new hires are given a pamphlet which includes information on Occupational Health and Safety, repetitive motion/musculoskeletal injuries and other documents to encourage employee wellness.

At Providence Place, all staff in all departments must be involved in the annual safety review which has nine different stations with a questionnaire that is filled out at the end. The stations include, naming a few: Slips, Trips and Falls, Safety in Moving and Lifting, WHMIS, The Respectful Workplace, Aggression and Violence and Shift Work.

Another activity that Providence Place has been involved in is Risk Assessment and Job Safety Analysis. Risk Assessment is a technique used to identify the health and safety hazards of specific tasks in order to reduce the risk of injury to workers. Job Safety Analysis (Task Ranking) is a method to document demands of assigned tasks. It compares the demands of the task to the abilities of the worker – benefiting workers on return to work programs. Job Task Analysis is a tool used to assist with an effective return-to-work program. It documents the physical and psychological demands of a worker's assigned work tasks. The Task Ranking Forms list all the tasks, general loss exposures, risk evaluation and controls. The purpose is to¹⁵:

- Identify health and safety hazards in new, modified, or existing jobs. Once hazards are identified, the risks of harm can be assessed & appropriate controls/precautions put in place.
- Provide or help develop written work procedures.
- Develop orientation, training, & inspection documents
- Provide reference documents during incident investigations.
- Prepare documents for anyone hired under contract.
- Identify and control undetected hazards.

At present, Providence Place has done a Task Ranking form for the RN/RPN/LPN positions and a Task Ranking form with a Job Safety Analysis for most of the tasks done by SCA/CCAs has been completed.

All employees in FHHR are on “Gateway Online” and will be able to track their education in the “My Talent” section.

In November 2012, there was a briefing to senior leaders (e.g., CEOs & Executive Directors) regarding Summary Offence Ticketing (SOTs). Subsequently there was a briefing for facility managers in December 2012. In January 2013, there was a Telehealth presentation provided to the Occupational Health Officers and Co-chairs of OH&S committees. In February 2013 every employee in FHHR received a letter and a brochure regarding SOTs. Effective January 2013, new hires receiving the Safety for Supervisors will also receive information on SOTs. Providence Place has

made a slide presentation available on each computer for staff to access and read. Additionally, the Saskatchewan Union of Nurses president presented every nurse at Providence Place with an eight page booklet with information on the different offences and the set fines. In April 2013 there is to be an information session for “in charge” and supervisory staff. The information provided indicates that the ticketing is planned to start as of July 2013. While the information is trickling slowly down and there is concern and confusion among the front line staff, as this has not been clearly explained to them and they feel that the ticketing is a punitive action.

2. *Sun Country Health Region (SCHR)*

The Sun Country Health Region has a monthly general orientation for all new hires in the region which is mandatory prior to starting their position. All employees have been trained in TLR (Object and/or Client Moving, depending on their position) and PART (intermediate and advanced) since the inception of general orientation in 2012. All new hires are also given an in-service at general orientation on falls prevention, patient safety reporting, workplace health and safety and disability management.

All employees in SCHR are on “Gateway Online” and coming in the future all staff will be able to track their education on the “My Talent” portion. This is where safety programs such as PART and TLR may be tracked.

In SCHR the OH&S leads meet with other regions across the province. At times there appears to be difficulty with information filtering down to others within the region. There were public consultation meetings held both in Weyburn and Estevan in February 2013.

The Department of Labor reviewed the changes to the OH&S Act and talked about the SOTs. It is the understanding of some within the SCHR that the SOTs have been tabled until January 2014, as it is felt that there is much discussion still to be had regarding this issue. It is important to note, however, that this has not been confirmed, nor did the others in our group receive congruent information from their respective health regions to support this statement.

3. *Saskatoon Health Region (SHR)*

All new Saskatoon Health Region employees participate in Welcome Onboard Week (WOW), which is a two to three day general orientation program that provides all staff with TLR Object Moving, with employees involved in transferring of patients also receiving further TLR training. TLR was approved by SHR in April 11, 2002, and has been incorporated in their regular training since that time.

The SHR converted from using PART to primarily using WAVE in 2010. SHR felt that PART was not suited for a big health region which provided safety training to numerous other health care providers besides nurses. PART is still utilized in the SHR in the areas in which they anticipate more aggressive patients to be located (e.g., The Dube Center in Saskatoon, a psychiatric center). The SHR offers different sessions (1, 3, or 8 hours) depending on what profession an employee belongs to, as well as the anticipated amount of hands-on patient care involved.

Education received at WOW training for TLR is recorded in a database. Individual departments are responsible for their employee recertification and subsequent documentation of this recertification. The Occupational Health Committees can choose to view this information but do not track recertification. In rural centers the managers provide a yearly education tracking sheet to OH&S which includes TLR as well as various safety issues for the region. Rural managers need to cross reference policy guidelines for their facility in gaining compliance by staff.

All employees in SHR are also on “Gateway Online” and will also be able to track their education with this tool.

In rural SHR, OH&S Co-Chairs from local representatives are invited to the regional OH&S meetings to represent their own committees. There does appear to be difficulty at times with the information filtering down from the regional representation to others within the region.

OH&S amendments and Summary Offense Ticket information sessions were offered in February 2013, for all SHR managers and employees who act in a supervisory role. The information provided during these sessions noted that in the event of an investigation which involved the failure to properly train workers, the onus would be on the employer to be able to provide

documentation that they provided appropriate training to workers, ensured it was explained by a competent person and that workers were assessed in some way to demonstrate they knew the information provided. Additionally, the sessions reinforced the fact that employees can be ticketed for violating certain identified sections of the Occupation Health and Safety Act and Regulations.¹⁶

V. *Impressions of Difficulties in the Current System*

Based on the environmental scan, discussions held with managers and front-line staff in various hospitals, combined with the personal work experiences of some of the group's members, the following apparent limitations of the current system were identified. The group does acknowledge that these potential "holes" in the system are based on perceptions held by those in management and those working in the front-lines and do not necessarily reflect the work which is actually being planned by those in government and within SASWH. Impressions of the group and concerns/issues noted by those interviewed include the following:

- a) There are a wide range of risk-based training programs available within the province. While utilizing different programs for different scenarios and situations is deemed to be appropriate, the group feels that having the same programs available throughout the province would allow for better collaboration, sharing of resources, and consistency among the health regions. Standardization of training programs could potentially enhance the province's ability to track employee training and ensure that employees are receiving the education that they require to work in a safe manner.
- b) Managers are primarily responsible for ensuring staff are trained and recertified at the appropriate times. There are limited tools available for managers to track training, though the Gateway Online does seem to be a hopeful option for tracking of training and recertification in the future.
- c) The type and amount of information being reported from each department upward to senior management, or externally to the government, appears to be inconsistent. In most cases, it appears that currently only WCB claims are reported out to the government body. In

an effort to be proactive and prevent injuries before they happen, the group would suggest it may be beneficial to assess additional measures of employee safety, such as number completing risk-based training programs and frequency/consistency of recertification.

- d) Differences in resources, both with regard to employee size and the adequacy of equipment, was noted as a challenge for rural sites as compared to the larger urban sites. A number of those interviewed in smaller centers noted difficulty replacing staff when employees are required to leave their regular duties for training, making the requirements for training difficult to operationalize. Additionally, some rural sites noted concern about not always having suitable or enough equipment to ensure the safe transferring of patients and objects.
- e) A number of those interviewed felt that the decision as to which techniques to use for unique situations, such as for bariatrics and pediatrics was left up to each individual health region. The group discovered that while there is not a known module for pediatrics, there actually is a specific training module available to provide recommendations as to how to manage bariatric patients. Some of the front-line staff who we met were not aware of the availability of this specific module. Clearer and more accessible information for these scenarios would likely be beneficial.
- f) Some of the supervisors and managers who were interviewed noted they felt that there seems to be minimal to no communication within and between the health regions in regard to employee safety. We did learn that there are relatively regular meetings between OH&S leads from across the province. Given the comments from those within the regions, it is suggested that there may be room for improvement in the dissemination of information discussed at these meetings to others within the regions.
- g) Those being trained to become trainers themselves are not necessarily aware of their role, the implications and the expectations of their position prior to receiving the training. We anticipate that this may differ from health region to health region and also between departments. Of those who were interviewed, there was an observation that some trainers do not return after the initial training sessions. Some may receive the training and realize that they do not enjoy leading a group. Alternatively, some

may find it intimidating when confronted with non-compliant staff. Others may feel they do not have the support of their management in fulfilling their role. For example, a trainer may get paid “regular time” to teach, but miss out on overtime in the front-line area in which they work. Similarly, a trainer who teaches for an eight hour shift may do so and sacrifice working a twelve hour shift on the floor that day. These scenarios may discourage trainers from continuing on with their training, resulting in inefficient use of train-the-trainer resources.

- h) Given the recent discussions around issuing Summary Offense Tickets against those who do not follow procedures and those in charge of employees who perform tasks in an unsafe manner, there is concern that front-line staff may be reluctant to report injuries which do occur. Some front-line staff are concerned that this approach brings health care back toward a culture of blame as opposed to the “just culture” in which the systems that may perpetuate errors can be fixed. Many front-line staff noted they need to feel more at ease reporting problems, which would in turn give employees a sense of accountability and engagement in system improvement.

VI. Recommendations to Potentially Improve the Process

In consideration of the aforementioned potential limitations, the group recommends the following as considerations which may have the potential to improve the current process:

- a) Create a unified approach, sharing the resources, ensuring the same programs are available to each health region, big or small, with SASWH being the “go-to” organization as a resource for all. Having online access to training program information, minutes from provincial OH&S meetings and an online forum to discuss questions and obstacles among the health regions available through the SAWSH website could enhance the collaboration and sharing of resources between regions and urban/rural sites. It would also provide an opportunity for increased communication across the province.

- b) Utilize technology to create a system whereby managers can track and report staff training certification and re-certification, consistently across the province. Upon nearing completion of this project, it did come to the group's attention that "Gateway Online" access is being utilized to track employee training by the employee number in at least one health region. We anticipate that, moving forward, employing this tool may make it easier for individual departments to record training and also to report out to the government and SASWH.
- c) Complete a Risk Assessment, Job Safety Analysis (Task Ranking) and Job Task Analysis Forms for each job description to identify risks, based on the employee's area of work. Risk Assessment would help identify health and safety hazards, evaluate the risk of each hazard and identify the controls for eliminating or reducing the risk in each hazard. This would assist in development or improvement of practices and procedures, incident investigations, improvement of workers training, identification of immunization/infection control issues and improvement of communication.
- d) Standardize equipment requirements across the province. Currently some rural facilities only have a few ceiling tracks lifts. Additionally, some centers have limited access to sit to stand and total lifts and so lifts are being transported across the facility numerous times per day which results in excess motion and transportation and is not felt to be "lean". Maintenance of the function of the lifts is occasionally not kept up, resulting in compromised function of the equipment (e.g., wheels not functioning properly), which increases the risk to the resident as well as the worker.

Standardization of equipment could potentially save health care dollars by,

- 1) Allowing for purchasing in bulk, thus lowering equipment prices,
- 2) Reduced training dollars if staff are employed in more than one facility/site/health region, and
- 3) Standardization of maintenance requirements.

For example, the FHHR is using the same Glucoscan machine across the region. If a staff member is employed at more than one facility they do not have to be trained and recertified in using different equipment, thus they are saving training dollars. The same could be done for other equipment such as ceiling tracks, sit to stand lifts, total lifts, electronic beds, blood pressure machines and other equipment in facilities. Facilities in small communities could benefit from lower priced bulk purchases.

- e) Determine how the compliance with the above programs actually impacts WCB stats year over year. Instead of assessing change at the end of the reporting cycle 2017, measure meaningful movement of change each year.
- f) Consider focusing on preventative measures, such as ensuring compliance with training programs, access to training resources and appropriateness of equipment, instead of punitive action through SOTs. It is felt that SOTs are generally trying to reinforce what is already there - following safety rules and regulations included in mandatory training programs.
- g) It is suggested that all rural facilities or larger areas could be funded for an out of scope safety leader position. Their primary responsibility would be to ensure the safety of employees and clients. These positions could implement and integrate the recommendations included in our project and be responsible for the compliance with safety initiatives laid out by OH&S, Infection Control, Respirator Fit Testing, Training Programs and subsequent tracking of the same.

It is important to note that some of the concerns the group has uncovered are being already currently being addressed by the system. As is often the case, the lag in action to observation simply did not make initial identification of improvement easily seen. This format does allow this project to flag areas for further work and focused attention.

VII. Conclusions

As a group we have surveyed our own individual health regions and compiled our findings to paint a picture of the current state of employee training in three health regions in Saskatchewan. Given the impact of nursing injury within healthcare, we narrowed our focus to principally include RNs, RPNs, LPNs, and SCA/CCAs. The group hypothesizes that this picture is reflective of the activity across the province within these sectors, but does acknowledge that realistically the findings can only be held applicable to these areas at this time.

Hopefully, the urban and rural combination of our group can be viewed as a good representation of the province at large. There is also a difference

between small and large regions. The impact of those differences needs to be considered in assessing program effectiveness. This can be seen in the availability of safety equipment in small regional affiliates or simply the difficulty backfilling positions to free staff up to take the training.

We found there is an apparent disconnect between health regions and an opportunity for improvement in communication throughout - from the front-lines, to upper management, through SASWH and ultimately to the Ministry of Health. The route of flow of information from the floor through the reporting agencies and ultimately on to the Ministry is not clear. This disconnect, leaves further room for regions to venture off on their own direction while trying to meet the Hoshin targets. We suggest that devoting resources to the development of a shared online resource would provide a medium for health regions to collaborate, prevent each one from having to “recreate the wheel,” and promote a consistent direction among the groups.

Communication and engagement of all levels of the system to change the cultural perception from one of blame to one of supporting safety-reporting seems critical for success. When the workforce feels comfortable to report issues, meaningful improvement would be expected to follow.

Finally, the importance of a healthy workforce in delivering the new streamlined version of care should be emphasized. We see the system-wide, top to bottom support for the lean approach and suggest that the same top-down commitment and energy should be connected to the transformation of the “Culture of Safety”. This dedication and focus could certainly facilitate the transformation of healthcare to provide a safer working environment for all.

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