Executive Limitation Monitoring Report
EL-6 Treatment of Staff and Volunteers
Lake of the Woods District Hospital

October 2017

Board policy is indicated in bold typeface throughout.

I hereby present my monitoring report on your Executive Limitations Policy EL-6 "**Treatment of Staff and Volunteers"** according to the schedule set out. I certify that the information contained in this report is true, and ***represents reasonable achievement of all aspects of the policy unless specifically stated otherwise***.

Signed _____, CEO Date: October 25, 2017

The CEO shall not cause or allow working conditions which are unfair, disrespectful, unhealthy or unsafe.

CEO Interpretation: no change

The CEO has comprehensively interpreted "unfair" and "disrespectful" in numbers 1 through 5 of the policy. Therefore, evidence for compliance with "unfair" and "disrespectful" is provided in my cumulative responses to items 1 through 5.
I interpret "unhealthy" to mean exposure of staff and volunteers to conditions that are known or ought to be known that are detrimental to the health and well-being of our staff and volunteers. These conditions must be under the control of the hospital and known to directly affect working conditions.
In addition to the board's policy item 3 below, I interpret "unsafe" to mean conditions where staff or volunteers would be at risk of sustaining preventable injury due to lack of knowledge and/or unsafe physical conditions.

Compliance regarding safety (unsafe working conditions) will be demonstrated when the standards shown in the chart below are met

Evidence: **Non-Compliant- 1 area WHMIS**

COMPLIANCE STANDARD & RATIONALE	ACTUAL RESULT	COMPLIANCE
Compliance with 100% of requirements of OH& S Act:		
a) OH& S included in orientation	a) OH&S included in Orientation – 100% - orientation checklists include all mandatory Health and safety requirements.	Compliant
b) Joint Occupational Health and Safety committee in place	b) Joint Occupational Health and Safety Committee in place	Compliant
c) At least one Certified worker rep on site	c) 100% (14/14) of JOHSC committee members are Level 1 certified - 4.6% (3/14) of JOHSC committee members are level 2 certified, however the remaining 11 members will take their level 2 training October 31 & November 1, 2017. This certification	Compliant

COMPLIANCE STANDARD & RATIONALE	ACTUAL RESULT	COMPLIANCE
	exceeds the OH&S requirements of 2 JOHSC members (1 Worker & 1 Manager.	
d) Inspections done per legislation (the entire building inspected at least annually but a portion at least once a month).	d) Inspection frequency exceeds OH&S legislative requirements – documented in administration and available to staff on the JOHSC bulletin board. Inspections are done by JOHSC members monthly, managers quarterly and Senior Managers at least twice a year	Compliant
e)Recommendations from JOHSC are addressed	e) There have been two recommendations sent from JOHSC to Senior management since the last report. One is resolved and the other is being addressed through the Workplace Violence Prevention and Management Task Force.	Compliant
f) Orders from MOL addressed	f) Orders from MOL responded to &/or addressed as per legislation. Documented compliance is kept in Occupational Health and Safety office and with the JOHSC committee Chairs. Last MOL "Health Care Initiative" inspection June 2017.	Compliant
g) 80% of staff have certified in WHMIS within the last year. This is a reasonable standard as there is always a percentage of staff whose certification has recently expired and they have not had the opportunity to recertify.	g) Percentage of staff certified in WHMIS: 73.8% (up from 67%). An email notice has been sent to all staff who need to recertify. This will be followed up by the manager of the department.	**Non-Compliant**
Emergency plans (Code Red, Yellow, White, Black, Green, Orange (CBRN), Gray, Purple, Pink, Blue, and Brown) are in place and practiced at least annually as required by Accreditation Canada's standard	All Code Drills have been completed on an annual basis	Compliant
We strive to decrease the number of staff incidents. Compliance will be achieved when the number of staff incidents is less than the 5 year average. There are always fluctuations in incidents which cannot be totally prevented and a 5 year	Data from Risk Monitor: 5 year average: **71.2** incidents 2012-13- 70 2013-14- 81 2014-15- 63 2015-16 - 76 2016-17 – 66	Compliant

COMPLIANCE STANDARD & RATIONALE	ACTUAL RESULT	COMPLIANCE
average is a reasonable representation of trend. Staff incidents include overexertion, exposure, verbal abuse, physical abuse, struck against, slips/falls, struck by, & caught in.	2017-18 to date - 38	
Staff Lost Time Injury Compliance will be achieved when the lost time incidents is less than the 5 year average. There are always fluctuations in incidents which cannot be totally prevented and a 5 year average is a reasonable representation of trend.	5 year average: 2 incidents 2012-13 - 1 2013-14 – 2 2014-15 - 2 2015-16 - 4 2016-17 – 1 2017-18 to date - 1	Compliant
100% of staff is offered free immunization against Hep B. 100% of staff is offered free immunization against Influenza.	100 % of the 49 new hires in 2015/16 were offered immunization in Influenza and Hepatitis B. We do not keep a formal record of staff who are hired with documented Hepatitis B immunization status vs those we offer this to on hire. Most new employees present with HepB immunization in place. Influenza: 2010 – 38% 2011 – 51% 2012 - 51% 2013- 62% 2014- 59% 2015 – 55.6% 2016 – 68%	Compliant (We cannot compel our staff to be immunized so having 100% of staff immunized is not possible) All new hire staff are offered HepB immunization. Many staff come to LWDH already immunized. This is noted on their OH&S file but is not tracked as a cumulative statistic. All staff are offered Influenza immunization- we cannot however, make this mandatory. An education campaign is carried out every fall to encourage staff to receive influenza immunization.
Meet MOL Requirement of Mask fit testing in high risk areas (ER, Inpatient units where patients are placed in isolation). Compliance will be achieved when 80% of staff have been Mask fit tested in the past 2 years. This is a reasonable standard as there is always a percentage of staff whose certification has recently expired and they have not had the opportunity to recertify.	OH & S Stats results: 2011 –90% 2012 – 100% 2013 - 85% 2014- 100% 2015 - unable to obtain statistics 2016 - unable to obtain statistics 2017 – 83.5%	Compliant This is the rate for all staff, not just those in ER & inpatient areas.

COMPLIANCE STANDARD & RATIONALE	ACTUAL RESULT	COMPLIANCE
Random check confirms exterior doors locked at night 100% of the time. Supervisor checks all doors every night and if a door is found unlocked an incident report is generated.	Review of Risk Monitor indicates no incidents identifying that doors were not locked. Security measures include locking of the lobby doors after 5pm and locking for 24 hrs on weekends. Locking inpatient units after visiting hours. Security Pass Cards installed on approximately 51 doors throughout the hospital which specified lock down times.	Compliant
Random check confirms doors in psychiatry and maternity in lockable condition 100% of the time	Psychiatry: 100% compliant based on monthly reports from psychiatry. Maternity: 100% Compliant. The system is checked each time a newborn is admitted and there have been no incidents of failure.	Compliant
Random check confirms Morningstar doors locked 100% of the time. If doors were found unlocked an incident report would be generated.	Door checks are done by staff daily. All persons presenting must be buzzed in.	Compliant

Compliance regarding healthy (unhealthy) working conditions will be demonstrated when the standards shown in the chart below are met:

COMPLIANCE STANDARD & RATIONALE	ACTUAL RESULT	COMPLIANCE
Exposure to second hand smoke is minimized.	A single outdoors designated smoking area has been assigned at each hospital site. Legislative requirement to be a Smoke-Free campus by January 2018.	Compliant
Risks of exposure to needle-stick injuries are addressed and eliminated.	Blood and Body Fluid Exposure Order Set recently revised and implemented. Location of prophylaxis medications expanded to include OR, ER and Mat to ensure timely access to treatment for staff. Potential exposures also reported in Risk Monitor. Committee reviews and make recommendations to reduce or eliminate risk. # needle-stick injuries to staff: - 2012-13: 2 - 2013-14: 5 - 2014-15 2 - 2015-16 – 3 - 2016-17 – 5 - 2017-18 – Q1&2 – 3	Compliant.

	Exposure to blood and body fluids: - 2016-17 – 5 - 2017-18 – Q 1 & 2 – 6	
Hand Hygiene alcohol based product is available at appropriate locations in all patient care areas.	Alcohol based hand hygiene product is available in each patient room as well as monitored areas in out-patient depts.	Compliant
Risks of exposure to harmful substances/chemicals- i.e. asbestos, mould, chemicals, medications are addressed through appropriate use of PPE (Personal Protective Devices) & barriers as required.	Exposure risk is controlled through the appropriate handling policies and procedures. All staff is trained to use the PPE required for their work. Safe Operating Procedures (SOP's) are in place for all exposure types. Mandatory annual review in place for high-risk activities.	Compliant
Environmental cleaning and disinfecting standards are maintained as per best practice and CHICA (Canadian Healthcare Infections Control Association) Standards.	Strict adherence to IP&C (Infection Prevention & Control) measures ensures both patient & staff safety & healthy working conditions.	Compliant as evidenced by low HAI (Hospital Acquired Infection) rates.

Further without limiting the scope of the above statement by the following list the CEO shall not:

1. **Operate without written personnel policies which clarify personnel rules for staff, provide for effective handling of grievances, and protect against wrongful conditions, such as nepotism and grossly preferential treatment for personal reasons.**

INTERPRETATION: (no change)
Compliance will be demonstrated when:

(a) Current written policies are in place for hospital employees, physicians and volunteers covering all of the areas according to best practice human resources legislation including salaries, benefits, record keeping, and labor relations issues such as union agreements, withdrawal of service, absenteeism, safety, progressive discipline and retirement.

b) The process describing how to report a grievance is imbedded in the negotiated collective agreements and for non union staff, within the conditions of employment. The grievance process provides two levels of appeal beyond the immediate supervisor.

c) There are policies in place regarding conflict of interest, including protections against preferential treatment or hiring, which direct "no special preferences" being given during the hiring process, or discriminatory treatment based on personal relationships or beliefs.

d) The grievance process is shown to be effective by resolution of all grievances within a mutually agreed upon time frame

Evidence: **Compliant**

(a) Human resource policies posted in Policy Tech, and are reviewed regularly.

b) An internal review of grievance processes verified there is a written process in place regarding how to report a grievance, that is consistent with negotiated collective agreements, and that a similar process exists for non union personnel.

c) Internal policies are in place, prohibiting conflict of interest and discriminatory treatment in hiring process.

d) **Annual Grievances Received**

Bargaining Union	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
ONA	6	3	1	2	3	10	5
CUPE 1781	0	2	0	0	0	2	1
CUPE 822	6	1	13	0	1	12	5
CUPE 3634	0	0	0	0	7	4	0
TOTAL GRIEVANCES`	**12 (7 withdrawn by the Union; 5 settled without prejudice)**	**6 (all resolved)**	**14 (12 withdrawn by the Union; 2 held in abeyance)**	**2 resolved (+2 held in abeyance from 2012-13 CUPE822)**	**11 (6 withdrawn; 2 resolved; 3 outstanding /advanced to arbitration)**	**28 9 withdrawn, 8 resolved, 6 future arbitration, 5 outstanding**	**11 4 withdrawn, 4 resolved, 3 outstanding**

1.1. Operate without processes to reasonably protect staff and volunteers from verbal or physical abuse

CEO Interpretation: (no change)
Compliance will be achieved when:

a) Policies and procedures and a code of conduct are in place to guide staff in framing their actions and conduct and the actions and conduct of others, and to report incidents and receive a response on action taken.

b) Staff have available to them tools (on line learning programs, Prevention of Violence / Respectful Workplace program, Crisis Prevention and Intervention (CPI) and education to enable them to anticipate and protect themselves in situations where they may be subjected to verbal and physical abuse.

c) All incidents of abuse and harassment (mistreatment or injury or threat to mistreat or injury) are investigated and actions taken to stop the abuse/harassment and all reasonable actions have been taken to prevent future incidents.

d) 90% of staff in areas where CPI (Crisis Prevention and Intervention) is required (Schedule 1, ER, Morningstar, Admitting) have been certified / recertified in CPI within the past 2 years. This is a reasonable standard as in any month one or two staff members can come up for recertification or are waiting for certification and since this training is offered on a schedule they may be waiting for a course.

Evidence: Non-compliant (CPI)

a) Workplace Violence Prevention Task Force reviewed and implemented assessments, protocols, and policies related to Workplace Violence.

A Respectful Workplace and Code of Conduct policy is in place to protect staff from abuse, discrimination and harassment. There is an incident reporting process in place (Risk Monitor) as well as an investigation and management process. All olicies are reviewed and revised as needed every 2 years.

b) A mandatory online training program on Prevention of Violence in the Workplace has been completed by all staff. There are two specific modules: one for general staff and one for managers. These modules were completed to meet Bill 168 and Workwell requirements.

b) A review of the data regarding abuse indicated:

Year	Verbal Abuse of Staff:	Physical Abuse of Staff:	Related Lost Time Incidents:	TOTALS:
2011-12	78	28	2	106
2012-13	76	48	0	124
2013-14	42	11	0	53
2014-15	23	15	0	38
2015-16	20	32	2	52
2016-17	59	71	1	71
2016-17 Q1	9	26		35

The number of incidents of verbal abuse of staff remains high. All incidents were investigated and corrective action taken where possible. We will continue to monitor.
Abuse of staff by other staff or physicians can result in implementation of the Progressive Discipline process and would prompt re-education re the Code of Conduct and Prevention of Violence /Respectful Workplace policies.

Reported incidents of abuse of staff by visitors/family would result in immediate intervention and investigation. The Visitors/Family would be informed about the Prevention of Violence / Respectful Workplace policy. Consequences of continued abuse would be explained and could include eviction from the premises.

Abuse of staff by patients was addressed by notifying patients that their comments / behaviors are abusive and must stop. Many incidents of verbal and physical abuse involved patients with a degree of cognitive impairment. Ongoing reminders are issued to patients regarding the code of conduct and consequences of abuse up to discharge from hospital or charges being laid for ongoing behaviors.

We have posted “zero tolerance of abuse” stop signs in all departments so patients understand what constitutes abuse (including swearing) and the consequences. We continue to train staff in high risk areas in Crisis Prevention and Intervention. We identify patients with a history of violent behavior as per Flagging/Acting out Behaviors policy so staff are aware and can be vigilant when dealing with these patients (as per Bill 168). Communication tools have been developed to ensure staff communicate a patient’s risk of violence at transfer of care.

	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
Staff-Staff Harassment Complaints	5	4	5	11	3	4	2

The 2 incidents involved perceived verbal harassment of one staff by another staff member or physician. Both incidents were resolved with meetings between affected staff and managers. No disciplinary action was required. EAP was offered to both staff. .

d) A Workplace Violence Prevention and Management Task Force was struck February 2016. The Task Force has representation from all unions and all internal and external departments within the hospital. The Task Force has developed and implemented the following strategies: Flagging of Patients with a potential for violence, Clinical assessment that assess actual risk of violence with accompanying protocols, review of withdrawal protocols, staff education, Code White review, Police protocols, etc.

e) Current CPI certification statistics are as follows:

	2011	2012	2013	2014	2015	2016	Oct 24/17
Schedule 1	86%	58%	91%	77%	60%	73%	74%
ER	92%	46%	88.5%	73%	86%	33%	22%
Morningstar	90%	90%	94%	55%	85%	82%	56%
Admitting	72%	32%	94.4%	85%	100%	86%	87%
AVERAGE	85%	57%	92%	73%	83%	68.5%	59.75%

When averaged, compliance is 59.75%. This is largely due to low certification in the ER. We have recently hired into 5 positions in ER, and are awaiting a CPI class to certify these new staff.

It is extremely difficult to reach 90% compliance with this indicator. Many staff book their recertification courses after the last course is expired. The effect leads to many staff "dropping" from compliance at the same time. We do hold courses over the summer months but have a minimum registration number to hold the course. We do not have the resources to teach one or two staff at a time. A concerted effort to reach compliance has begun and will be in place by Dec.31/17. There are many other depts. and areas who attend CPI training- such as Challenge Club staff, Hospital Attendants, Nursing Supervisors, Patient Unit Managers, Social Workers, Mental Health & Addictions Staff, Maintenance & Housekeeping staff, the Nursing Resource Team and Sexual Assault/Domestic Violence staff. The course is open to any staff member who would like to complete this safety training.

2. Permit employees, volunteers, Hospital Auxiliary members, Foundation members and physicians to work without adequate orientation to the organization's policies, procedures, facilities and equipment appropriate to their work assignment.

CEO Interpretation: (no change)

I interpret "orientation" to mean a formal process of familiarizing staff with the physical plant, policies, processes and procedures, equipment, personnel, health and safety issues and all other information needed to perform the basic requirements of their job.

Compliance will be achieved when:

a) There is evidence that all new staff and volunteers have participated in orientation which reviews general hospital wide policies as well as policies and procedures specific to the work area, equipment and the physical environment. This evidence is in writing in the personnel file.

Evidence: **Compliant**

a) A review of the HR files verified that 100% of new staff have completed a comprehensive orientation program as evidenced by completed orientation checklists present in their files. The new hire orientation manual is reviewed and updated by Human Resources annually and as needed through the year if changes are required.

3. Operate without sufficient staffing to provide for staff and volunteer safety

CEO Interpretation: (no change)

I interpret "sufficient staffing" to mean adequate staff to perform the work in a safe manner within the hours of the assigned shift.
Compliance will be achieved when:

a) All staff have a mechanism to report staffing situations that are unsafe.
b) 100 % of improper work assignments submitted are resolved to the satisfaction of both parties. Lack of agreement will result in application to the Independent Assessment Committee.
c) 100 % of reports of unsafe workload by non nursing staff are resolved to the satisfaction of both parties.

Evidence: **Compliant**

a) When a staff member feels that the workload is beyond the staff member's ability to provide safe patient care the staff member(s) completes a Professional Responsibility Workload (PRW) report form. All of the bargaining unions have a mechanism to report incidents where they feel that their workload is such that they can not meet their Professional Practice Standards. This right is

imbedded in the collective agreements. Appropriate "Stop Work" policies are in place as per OH&S Legislation.

b) A review of PRW forms, submitted in 2016 verified that 100% of complaints were resolved by the Hospital and the Association. The increase in PRW forms received from ONA can be attributed to many factors. Partially to the election of a new local union executive as well as direction from ONA Central to be vigilant regarding contractual issues- ie the replacement of RN shifts and all workload issues. Maternity/Acute Medicine/Pediatrics amalgamation has also been a contributing factor as we have experienced a very high patient census and high level of patient care needs. The PRW process offers a venue for ONA staff to communicate their concerns & for management to respond.

	2010	2011	2012	2013	2014	2015	2016	2017 (to date)
Professional Responsibility Workload (PRW) Complaints	10	9	9	6	14	27	37	11

All PRW's are discussed with the union and discussion shared with staff submitting the form. Strategies to address a similar situation in the future are identified when possible and agreed upon.

c) A review verified there have been no improper workload reports from the CUPE bargaining unions representing non nursing staff or non-union non-management staff. CUPE Nursing staff (RPN's) may co-sign an ONA PRWF. When this occurs, a response is made to those staff as well.

4. Permit employees and volunteers to perform their required function without adequate training or evidence of adequate training

CEO Interpretation: (no change)

Compliance will be achieved when:

a) 100 % of staff has received orientation to their job sufficient to perform the essential requirements of their job independently.

b) RHPA (Regulated Health Professions Act) staff have demonstrated competence through successful renewal of their certificate of competence with their regulatory college annually.

c) Safe operating procedures are in place for moderate to high-risk procedures/activities/equipment.

Evidence: **Compliant**

a) 100% of service staff have received on site training as part of their hospital and departmental orientation and this training is recorded in their Human Resources file. The results from the Worklife Pulse tool (through Accreditation) done in 2014 indicated that 98% of respondents responded that they were clear about what was expected of them on the job. (n = 265)

b) Annually, the nursing office submits an "Annual Automated Verification of Membership Renewal" to the College of Nurses on Ontario (CNO). This document lists all nurses employed by LWDH and identifies them by registration number, category and name. Verification is returned by the CNO and identifies all those "Entitled to Practice". This information is filed by Human Resources.

Other Regulated Health Professionals such as social workers or physiotherapists file their annual maintenance of competence with Human Resources by providing a copy of their annual certificate of registration/competence. A review for indicates 100% compliance with this process.

c) Safe Operating Procedures - The MOL (Ministry of Labour) requires that moderate to high-risk equipment used by employees has a documented "SOP" in place. As new equipment is purchased, an SOP is developed by the department manager prior to first use. Assistance from the Staff Health Physiotherapist is available to managers on request. At the present time, we are compliant with all requirements to meet Ministry of Labour Safe Operating Procedure training.

5. Allow staff to be without a comprehensive staff wellness program

CEO Interpretation (no change)

Compliance will be demonstrated when:
(a) There is an active staff Wellness Program in place.
(b) The program seeks to establish and sustain health, wellness and well-being of staff.
(c) The hospital has participated in the annual Ontario Hospital Association (OHA) Quality Healthcare Workplace recognition program.

Evidence: **Compliant**

a) Introduced in 2008, the Workplace Wellness program has been very successful not only to improve staff health but also working conditions through education, activities and health promotion events.

	2014/15	2015/16	2016/17
Wellness Events – lunch and learns, wellness challenges, etc.	34	28	37

These events are well-attended and appreciated by staff. We have received direct feedback that confirms the value of this program to staff. Established Terms of Reference are in place to guide the program activities.

Wellness is tracked through monitoring of sick/absence stats. There is a well-established Attendance Awareness program in place to assist staff in maintaining and achieving good attendance at work. LWDH Wellness Committee seeks to improve staff health through a variety of programming available to all staff & volunteers. Participation is voluntary. Staff can complete a "Passport to Health" annually with a reward for completion of a number of healthy in-services/programs. The "Passport to Health" has been recognized as an innovative and successful strategy to promote staff health and participation in the program. The "Passport to Health" was also recognized with a Certificate of Merit from Excellence Canada.

	2014	2015	2016
Passport to Health Participants	56 staff	83 staff	59 staff

b) The hospital has a very active Sunshine Club that organizes and promotes staff events throughout the year. The Sunshine Club is funded predominantly through staff contributions.
c) The hospital recognizes various professions through the year with planned events. Ie: Nurses week, Rehab week, Social Work week, etc.
d) The LWDH continues to pursue recognition for excellence in staff health by an annual application to the OHA Quality Healthcare Workplace Program. In 2013, we received Silver level recognition. In 2014 and 2015, we received Gold level recognition. Unfortunately the OHA has not accepted application in 2016 and 2017 as they are evaluating the criteria and considering revamping of the program. We will continue to monitor.