A Pilot Project to Evaluate the Health and Safety Management System (HSMS) developed by the Ontario Safety Association for Community and Healthcare (OSACH)

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Ontario Safety Association for Community and Healthcare (OSACH) Health and Safety Management System (HSMS): A Pilot Study to Evaluate OSACH HSMS

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A Pilot Project to Evaluate the HSMS by OSACH
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Executive Summary

Recently (2006-2007), the Ontario Safety Association for Community and Healthcare (OSACH) developed a unique Health and Safety Management System (HSMS) to assist organizations to advance and link a culture of health, safety and wellness and focus on employee safety and wellness. Two key steps are included in the HSMS: integrating safety into an organization’s core business and motivating an organization to achieve employee health, safety and wellness through the implementation of one rapid cycle improvement initiative during the first year.

A process evaluation was used to evaluate the approach and effectiveness of the program. The Nursing Health Services Research Unit at McMaster University was contracted to conduct the evaluation of this new system. Six sites from various community and healthcare organizations consented to participate in the pilot project. All provided quantitative data for analysis. In addition, three sites participated in a qualitative study using a case study approach. The one-year research project was supported by the Ministry of Health and Long-Term Care (MOHLTC).

The process included site visits, interviews with various key stakeholders at each organization as well as the OSACH consultants, surveys and document analysis. All sites indicated that the OSACH HSMS benefited their organization. Although all organizations involved in the project had significant infrastructure in place before the pilot, each indicated that the program and the consultant model assisted in the development of a more robust infrastructure to support and advance the culture of safety and link staff safety and wellness with patient safety. Thus creating “a more balanced and comprehensive framework for safety at the organization.”

Organizations highlighted that the OSACH HSMS was thorough and highly structured and that participation in the pilot project resulted in more safety-related initiatives than they would have engaged in on their own. Sites identified many examples of improvements made during the HSMS pilot project to advance the overall safety program. All believe a program such as the HSMS will contribute to advancing a culture of safety and that staff safety is equally as important as patient safety. At each site, one rapid cycle improvement initiative was identified and all are in various stages of implementation.

The lack of standardized data made across site comparisons difficult. A standardized approach to a safety wellness programme across all organizations would assure alignment with a common set of indicators. Exemplars and best practices in employee safety and wellness are identified and could be used for system wide distribution.
Recommendations

The following recommendations are made to guide the Ontario Safety Association for Community and Healthcare (OSACH) and assist organizations that adopt the Health and Safety Management System (HSMS) as the framework for advancing staff safety and wellness and the overall culture of safety at their organization.

Infrastructure to Support a Culture of Safety

1. OSACH should continue the use of the HSMS to improve staff safety and wellness and the overall culture of safety in organizations. The approach uses the consultant model to support the delivery of the program. The level of support has to be customized based on unique organizational needs.

2. OSACH should target small to medium size organizations where resources may be more limited.

3. OSACH should encourage participant organizations to do an initial assessment of the following key elements prior to implementation of the HSMS:
   - The vision, mission, values and strategic priorities of the organization clearly articulate the commitment of the organization to patient and staff safety.
   - A communication strategy to ensure safety is “top of mind” for all those involved with the organization. It should maximize the use of technology and accommodate the various learning styles of staff.
   - The safety framework should link all aspects of patient and staff safety and wellness and support a blame-free culture.
   - The safety framework should relate to the existing quality improvement and risk management program.
   - Current safety-related policies and procedures should include a system for regular review and revision.
   - The committee structure should clearly define the accountabilities of committees and relate them to the safety framework.
   - A user friendly and comprehensive incident reporting system which provides timely and meaningful data to the appropriate parties.
   - A clearly articulated governance accountability framework for safety.
   - A corporate scorecard/dashboard which includes safety-related indicators and regular reporting to the board, management and staff. Indicators could include worklife satisfaction, absenteeism/overtime rates, staff injury/accident rates and related claim costs, worker retention rates and NEER assessment rates.

4. Organizations supported by OSACH should develop an overall framework that links all aspects of patient and staff safety and wellness into one comprehensive “picture” of what is included in the organizational vision for safety.
Workforce Planning and Human Resources Considerations

5. Organizations should utilize workforce planning/profiling tools and concepts to plan for adequate staffing to support a culture of safety. *

6. Organizations should develop a long-term comprehensive plan to support safety-related programs, preventive education and training programs for staff.

Further Considerations for OSACH

7. OSACH could work with partners such as Accreditation Canada, Quality Management Institute, Canadian Standards Association, Workplace Safety and Insurance Board and others to determine linkages and opportunities to advance staff safety and wellness.

8. OSACH should work with the Canadian Standards Association to validate the HSMS tool as meeting the requirements of the CSA Z1000 through the Quality Management Institute.

9. OSACH could identify exemplars/best practices in employee safety and wellness and create an inventory of best practices for wide distribution. Areas of best practice to consider include communication strategies, recognition systems and advancing a blame-free culture.

10. OSACH should work with others such as the Canadian Institute for Health Information and the Ministry of Health and Long-Term Care to define a common set of data elements with standard definitions, which would be collected at all organizations and demonstrate outcomes for staff safety initiatives and enable comparison across organizations. OSACH should review the indicators contained in pillar 2 of the 5 pillar HSMS program to ensure alignment with this common set of indicators. OSACH could also work with the Quality Management Institute and/or Local Health Integration Networks to advance standardization relating to the collection and analysis of employee safety indicators.

11. OSACH could work with key stakeholders to develop a toolkit which organizations can utilize to build awareness and engage their medical staff in staff safety and wellness initiatives.

12. OSACH could explore opportunities to develop educational materials focusing on staff safety and wellness topics using various media, which could then be provided/marketed to organizations.

13. OSACH could support the development of a longitudinal study that tracks specific indicators and how the HSMS impacted the overall organizational culture of safety.

14. OSACH and/or the participating institutions could also examine the linkage between organizational safety culture and patient outcomes/satisfaction.

Introduction

Recently (2006-2007), the Ontario Safety Association for Community and Healthcare (OSACH) developed a unique Health and Safety Management System (HSMS) to assist organizations to advance and link a culture of health, safety and wellness and focus on employee safety and wellness. Two key steps are included in the HSMS: integrating safety into an organization’s core business and motivating an organization to achieve employee health, safety and wellness through the implementation of one rapid cycle improvement initiative during the first year.

A process evaluation was used to evaluate the approach and effectiveness of the program. The Nursing Health Services Research Unit at McMaster University was contracted to conduct the evaluation of this new system. Six sites from various community and healthcare organizations consented to participate in the pilot project. All provided quantitative data for analysis. In addition, three sites participated in a qualitative study using a case study approach. The one-year research project was supported by the Ministry of Health and Long-Term Care (MOHLTC).

National and Provincial Overview of Health and Safety

Patient safety research has burgeoned in the United States (US) and elsewhere, while researchers in Canada are only beginning to assess the safety of our healthcare system (Baker & Norton, 2004). A search of the literature revealed a paucity of research linking employee safety with patient safety outcomes. As healthcare in Canada evolves, occupational health and safety continues to be an important concern for both the nation and the world. The push for reform in Canada originated with the publication of two seminal reports in the US: To Err is Human: Building a Safer Health System (Kohn, Corrigan, & Donaldson, 2000) and Crossing the Quality Chasm: A New Health System for the 21st Century (Institute of Medicine, 2001). These reports underscored the magnitude of healthcare errors in the US and detailed recommendations concerning how patient care and the work of healthcare teams should be modified. The federal government of Canada responded by supporting the establishment of a number of organizations with specific patient and occupational safety mandates. The Canadian Patient Safety Institute (CPSI), an independent not-for-profit corporation, was set up in 2000 to be a national leader on the issue of patient safety. The organization is concerned with the following:

- Fostering a system where knowledge and information about evidence-based safety practices is shared.
- Influencing the necessary cultural shifts and championing system wide changes to improve patient safety.
- Collaborating with stakeholders in an ongoing dialogue to support improvements in patient safety.

The CPSI works together with the Canadian Coalition on Medication Incident Reporting and Prevention to ensure a stronger patient safety system. Another important initiative, instigated in 1999, is the Institute for Safe Medication Practice. Its mandate involves collaboration with the healthcare community; regulatory agencies; policy makers; provincial, national and international patient safety organizations; the pharmaceutical industry; and the public to promote safer medication practices. The Royal College of Physicians and Surgeons of Canada forum on patient safety took place in 2001, followed by the founding of the National Steering Committee on Patient Safety in 2002.
Since 1994, the Canadian Institute for Health information (CIHI), an independent, pan-Canadian, not-for-profit organization, has been working to improve the health of Canadians and the healthcare system by providing quality health information (CIHI, 2008). The Workplace Health and Public Safety Programme serves hundreds of thousands of people each year by helping to protect the health and safety of federal workers and public servants, visiting dignitaries and the traveling public within Canada. The Canadian Centre for Occupational Health and Safety promotes a safe and healthy working environment by providing occupational health and safety programs across the country, and Accreditation Canada (formerly Canadian Council on Health Services Accreditation) provides leadership in the journey to quality healthcare services. In recent years, the focus on patient and staff safety has been enhanced through the inclusion of required organizational practices (ROPs) relating to safety within the accreditation process. Compliance with ROPs is tied to the accreditation recognition structure.

In Ontario, OSACH assists healthcare and community sectors to achieve safe and healthy work environments through the prevention and reduction of workplace injuries, illness and disease. OSACH is a “designated entity” under the Workplace Safety & Insurance Act and is a non-profit corporation focusing on the promotion of a culture of safety.

Patient Safety in Canada

Patient safety-related outcomes in the Canadian healthcare system have shown that nearly 1 out of every 10 patients across the country reported being given a wrong medication or dose in the past two years. Similarly, 3 in every 20 Canadians reported experiencing an adverse event (the most common type being hospital-acquired infections), with close to 46% of these resulting in serious health problems. The CIHI also reported an average of over 1,700 birth traumas per year from 2003-2004 to 2005-2006 in Canadian hospitals outside of Quebec. These included injuries to the scalp and nervous system or fracture of the skull during the birthing process, which led to longer hospital stays for mothers and babies. Obstetrical trauma during childbirth was suffered by 1 out of every 21 women undergoing a vaginal delivery. On average, from 2003-2006, over 200 reported foreign objects per year (sponges or instruments) were not removed after surgical procedures. The CIHI reports that nearly 3.6 out of every 1,000 patients in Canadian hospitals outside of Quebec and some parts of Manitoba experience pulmonary embolism or deep vein thrombosis (CIHI, 2004, 2008). The 2008 CIHI report highlights a positive correlation between risk, advancing age and incident rates. Nearly 1 in 1,000 seniors admitted to an acute care hospital fractured their hip during their stay – over one per day (CIHI, 2004, 2008). In delving slightly deeper, the CIHI uncovered that approximately half of primary care doctors surveyed reported that there was no process for finding and preventing medical errors where they work (CIHI, 2004, 2008).

The adverse event rate in Canadian hospitals is estimated to be 7.5 per 100 adult hospital admissions. Although only 36.9% of the events are considered preventable, 20.0% are associated with permanent disability or death. A study involving four randomly selected hospitals (1 teaching, 1 large community and 2 small community hospitals) in each of five provinces (British Columbia, Alberta, Ontario, Quebec and Nova Scotia) indicated that surgery-related events were the most common, followed by drug-related or fluid-related incidents (Baker & Norton, 2004; Baker et al., 2004).

Historically, occupational health has been reactive and focused on incident/accident prevention, investigation and follow-up. The focus for the future is more proactive and includes prevention, support programs (e.g., critical incident stress debriefing) and wellness programs (e.g., ergonomics to prevent staff injury) in addition to the more traditional role. This broader focus also allows for other programs aimed at keeping staff safe and well in performing their work (e.g., non violent crisis intervention) and employee assistance.
Occupational Health

The World Health Organization (WHO) has a longstanding interest in global occupational health and emphasizes the need for the following:

- Promotion and maintenance of the highest degree of physical, mental and social well-being of workers in all occupations.
- The prevention amongst workers of departures from health caused by their working conditions.
- The protection of workers in their employment from risks factors adverse to their health.
- The placing and maintenance of workers in an occupational environment adapted to their physiological and psychological equipment.

In 2008, the Workplace Safety and Insurance Board (WSIB) of Ontario reported a total of 252,985 workplace injuries/illness in 2007\(^1\), with a subsequent total of 379 deaths from occupational injury and disease\(^2\). The concept of occupational health is particularly important in the healthcare sector due to the client population and nature of the work. In 2006, OSACH released the results of a study on the injury demographics across sectors within the province. Health and community care reported elevated incidents in the musculoskeletal disorders (55%) as well as slips and falls (15%). Overall, the association published a total of 8,903 lost time injuries within the one-year period (OSACH, 2006).

The concept of occupational health focuses on three main objectives to reduce and eliminate work-related injuries:

1. The maintenance and promotion of workers’ health and working capacity.
2. The improvement of the working environment and work to become conducive to safety and health.
3. Development of work organizations and working cultures in a direction that supports health and safety at work, and thus promotes a positive social climate and smooth operation and may enhance productivity of the undertakings.

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\(^1\) In 2007, the total 252,985 lost time injuries/illnesses are broken down into 80,863 allowed lost-time injuries/illnesses (worker loses time from work after the day of injury/illness and/or loses wages as a result of temporary or permanent work-related impairment) and 172,122 allowed no lost-time injuries/illness (worker does not lose wages but incurs health care costs as a result of a work-related impairment).

\(^2\) In 2007, the 379 total deaths are broken down into 100 deaths from Deaths from traumatic injuries and other immediate causes and 279 deaths due to occupational disease.
The Ontario Safety Association for Community and Healthcare - Health and Safety Management System

HEALTH AND SAFETY MANAGEMENT SYSTEM

The HSMS developed by OSACH (2007) is a “blueprint for building a culture of safety and health for both clients/patients and staff, building a system of care that links the relationship between the environment, culture, system/design and human factors to achieve safety solutions and quality outcomes.” It is a new approach that focuses on employee health and wellness. In order to test the system, OSACH implemented it as a one-year pilot project that included a research component.

Six healthcare organizations initially consented to participate in the pilot project. The objectives for the pilot project were as follows:

1. Evaluate the HSMS program and the improvements needed to make the approach generalizable to healthcare.

2. Assess the impact of the HSMS on advancing a culture of organizational safety.

**HSMS INCLUDES FIVE PILLARS**

- Leadership and Commitment
- Risk Identification and Analysis
- Risk Management and Control
- Evaluation and Corrective Action
- Strategic Review and Continual Improvement

The HSMS program includes a comprehensive assessment of compliance relating to each of the five pillars, the development of action plans to achieve full compliance, education and training sessions to support needs identified through the assessment process and the implementation of one rapid cycle improvement process relative to employee safety, which would contribute to the advancement of the overall safety culture. Ongoing support and guidance was provided throughout the project by an OSACH consultant assigned to each organization.

**THE OSACH PROCESS**

The OSACH process included an introductory educational session about the HSMS and identification of a Steering Committee. The OSACH consultant assisted each organization to complete a comprehensive assessment in collaboration with the Steering Committee to establish the current compliance level with statements relating to each of the five pillars. An action plan was then developed to address deficiencies. The plan helped the organization define top priorities for improvement, identify education and training needs and one rapid cycle improvement project relating to staff safety and wellness that would be implemented during the pilot project. The OSACH consultant documented organization-specific action plans to address any gaps in the current system and identify both challenges relating to the implementation of the HSMS and areas for improvement in the actual HSMS tools. The consultant also provided education and training sessions on an as needed basis, ensured the baseline quantitative data regarding the organization was submitted and updated the action plan as the project neared completion.
Evaluation of the OSACH Health and Safety Management System

The objective of this research study was to evaluate the effectiveness of the HSMS as a systematic approach to advance an overall organizational culture of safety and look at the following:

- HSMS implementation in the organization in relation to the projected outcomes identified by each pilot site.
- HSMS assessment tool, education and training sessions and consultant coaching.
- HSMS process and design.
- A process evaluation approach involving a more intensive case study assessment was used to investigate the effectiveness of the OSACH HSMS.

METHODS AND SAMPLE

The process evaluation of the HSMS was implemented at three of the pilot sites using mixed methods with both a qualitative and quantitative approach. It looked at the effectiveness of HSMS implementation and included a pre and post intervention evaluation. Data were collected before (pre) and after (post) the system was implemented in the organization. Due to the short timeframe, the post implementation evaluation consisted of a progress report outlining changes since the start of the project.

A two-tier evaluation methodology was used. All six sites participated in initial profile and baseline data collection. Only three of the six sites participated using the more intensive case study assessment approach. The following organizations were involved in the process evaluation:

- Halton Region Services for Seniors Division
- The Ottawa Hospital
- West Park Healthcare Centre

The following organizations participated in the baseline data quantitative aspects of the project:

- The Hospital for Sick Children
- Norfolk General Hospital
- North Bay General Hospital

The first tier data collected for all six sites included:

i. Existing safety, health and wellness profiles for each pilot organization including organizational integration indicators (generic and organization-specific quantitative and qualitative data); and baseline data of key qualitative and quantitative indicators of employees and patient health, safety and wellness (see Appendix A for a summary of all quantitative information provided by the six organizations).

ii. An assessment of the HSMS five pillars (including gaps and opportunities) and the development of an action plan to achieve compliance, which was completed by OSACH consultants.
Originally it was anticipated that data would be updated at the conclusion of the pilot. This was not possible given the duration of the project as most data elements are only collected annually. In addition, all six pilot sites participated in the HSMS program design evaluation by completing an online survey tool upon completion of the research project (see Appendix B).

The second tier data included a more intensive approach for the three case study pilot sites. Data collected pre and post HSMS implementation included the following:

i. Stakeholder input and analysis of notes taken during site visits. Stakeholders included steering committee members, senior leadership, managers and staff (see Appendix C).

ii. Document analysis (i.e., assessment reports, action plans and observation logs collected throughout the implementation process by the OSACH consultants and the research team) (see Appendix D).

**ON-SITE VISITS**

There were three on-site visits for each of the three case study pilot sites. During the first visit, the research manager accompanied the OSACH consultant to discuss the HSMS program and clarify any aspects of the research project. The second and third visits involved only the research manager. The second visit (pre implementation visit) occurred prior to the completion of the pillar assessments, delivery of the education/training modules by the OSACH consultant and finalization of the rapid cycle improvement initiative. The third visit (post implementation visit) occurred after completion of all pillar assessments, education and training sessions were delivered and the organization was engaged in the rapid cycle improvement project.

**INTERVIEWS**

During the pre and post implementation visits, data were collected through structured interviews with a minimum of four groups: senior leadership, the Joint Health and Safety Committee (JHSC)/Implementation Committee (IC) and representative groups of management and staff. At the three sites involved in the process evaluation, a common data collection tool (see Appendix C) was utilized for the pre and post implementation visits. In organizations where the OH & SC differed from the IC, both were interviewed. However, the information obtained from these two groups was aggregated for analysis. At some multi site organizations, two groups of management and staff were interviewed and their data were aggregated.

Table 1 outlines some characteristics unique to the pilot sites undergoing the more intensive process evaluation. They assist in understanding the pre and post implementation findings. Appendix E provides a site profile summary and detailed information on each of the organizations.
Table 1  Characteristics Unique to Case Study Sample Participating in the Process Evaluation

<table>
<thead>
<tr>
<th>Halton Region Services for Seniors Division</th>
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<tbody>
<tr>
<td>• Applicability of the HSMS to their organization, which is governed by the Municipal Act; thus orientation of governing body is not solely focused on health care.</td>
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<tr>
<td>• Multi site organization and sites are at different stages of preparedness.</td>
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<tr>
<td>• Organization has grown quickly; most sites have been built in past three years.</td>
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<tr>
<th>The Ottawa Hospital</th>
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<tr>
<td>• Multi site organization and sites are at different stages of preparedness.</td>
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<tr>
<td>• Bilingual organization so all programs should be offered in both official languages.</td>
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<tr>
<td>• Rotating and large numbers of medical students make program delivery a challenge.</td>
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<th>West Park Healthcare Centre</th>
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<td>• Single site organization with a specialized role, which results in some unique safety needs (e.g., scooter safety).</td>
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</table>

**PROCESS EVALUATION**

Responses to the interviews and focus group questions were transcribed at the time of the interview. Thematic analysis of the following was carried out: (i) Interview Records - pre and post implementation (3 sites) for all groups interviewed; (ii) Consultant Process Evaluation Log (3 sites); (iii) Health and Safety Management System Action Plan (2 sites); and (iv) Safety Profile of Sites - pre and post implementation. A thematic analysis of the quantitative findings was undertaken to determine themes, possible correlations and the impact of the HSMS program on the organization’s culture of safety. In addition each site (n = 6) submitted baseline quantitative data regarding their organization at the beginning of the project (see Appendix A). Conclusions were drawn for the case study experiences and organizational data. Recommendations were developed from the themes and findings of the pre and post evaluation and the online evaluation.

**DATA ELEMENTS**

As part of the data collection carried out by the OSACH consultants, detailed statistical information was requested from each organization. The data elements selected were determined by the research team with input from the MOHLTC and the OSACH consultants. A number of the elements are required for reporting to the MOHLTC and others are calculated by the WSIB. The information was obtained from the organizations through the OSACH consultant assigned to the organization. The organizations provided their data to the OSACH consultants who then forwarded the completed forms to the researchers for assembly of the information.

**POST IMPLEMENTATION SURVEY**

An evaluation of the HSMS design was also undertaken and included an online survey forwarded to all six organizations and the OSACH consultants to determine the impact of the HSMS program and opportunities to improve the actual HSMS program. A focus group meeting with the OSACH consultants also took place to obtain more detailed information concerning opportunities to improve the HSMS.
Findings

DATA ELEMENTS ANALYSIS

The information provided is presented in Appendix A. The researchers reviewed the data provided and identified several key issues. Some measures use fiscal years, while others use calendar years. For elements reporting numbers, the inclusion of denominator information would have allowed comparison across organizations. Actual numbers of staff may be preferable for some elements, while full-time equivalents (FTEs) are more appropriate for others. A number of data elements appear to have different definitions or units of reporting across organizations (e.g., vacancy rate, absenteeism rate, number of work accommodations, short- and long-term disability rates and training information). The WSIB statistics have the benefit of calculation by the WSIB; hence a standardized and consistent method is applied across organizations. Finally, some measures related to patient and public safety are either not collected at the present time or are not being shared externally.

The following observations related to the collection of the data elements are noted. Even though many of these indicators are basic human resource information required for reports to the MOHLTC, there were still problems in the availability of data in some organizations. In addition, in spite of the attempts to provide definitions of the various data elements, there was variability in how the data were expressed. In particular, when organizations were asked for the vacancy rate data element, there were at least two different calculations of vacancy rates submitted. Even if data appeared to be answering the appropriate question, it was presented in different ways. For example, number of registered nurses aged 55 years and older. Furthermore, some data, presumably reported to the MOHLTC, was reported by fiscal year, while other data was reported by calendar year. Observations related to the various data elements are included in Appendix A.

THEMATIC ANALYSIS

During the thematic analysis for the pre and post implementation visits, general themes emerged and are discussed below.

UNDERSTANDING OF THE OSACH AND HSMS

Pre Implementation Site Visit

At the senior leadership level, a general awareness of both OSACH and the HSMS was evident. However, other than championing safety and assigning a member of the senior team to oversee the program, it was unclear to the senior team what other roles it might play. Similarly, members of the OH & SC and IC were aware of OSACH and the HSMS, but they were unclear about the specifics of the program. Clinical management and staff generally had very limited or no awareness of the program.

Post Implementation Site Visit

Members of senior leadership described a significant shift in their knowledge level as a result of their active involvement in the pilot project. They described their knowledge level of the HSMS as “reasonable” to “extensive.” They provided concrete examples of activities undertaken such as “walkabouts” and “safety focused discussions with staff groups” to advance the overall organizational culture of safety. The OH & SC and IC members also reported an enhanced knowledge/awareness regarding OSACH and the HSMS.

Managers and staff generally continued to be unaware of OSACH and HSMS, unless they participated on a committee with direct involvement in the project. Management staff who participated in OSACH education sessions during the project had a slightly higher
awareness level of OSACH, but not HSMS. Generally, staff indicated they perceived enhanced organizational attention being paid to staff safety-related matters, but they could cite nothing specific.

At the introductory visit, there was no awareness that the pilot project included the implementation of a rapid cycle improvement activity, except by the senior leadership team which identified it as an opportunity to address a pre-existing staff safety-related issue of concern. By the post implementation site visit, managers and staff involved in the rapid cycle improvement project were aware of changes that were planned/had been implemented as a result of the HSMS.

**ORGANIZATIONAL COMMITMENT TO SAFETY AND THE OVERALL FRAMEWORK FOR SAFETY**

**Pre Implementation Site Visit**

The Chief Executive Officer (CEO) at each organization led the decision making process to participate in the HSMS program and assigned accountability for this project to a member of the senior team. All organizations have a senior leader who acts as the corporate sponsor for safety. This individual actively participates in the OH & SC.

Managers and staff at all organizations indicated that “the organization is doing a good job” of trying to support staff safety and wellness. All organizations include a reference to safety in their vision, mission, values or strategic directions/priorities, although some indicated intent to strengthen safety in these documents.

A comprehensive document which links all aspects of patient and staff safety and wellness into an overarching framework for safety was not evident in any organization. However, all viewed implementation of the HSMS as a means to enhance their culture of safety and entrench a more comprehensive and robust approach to safety (including monitoring) within their organization.

The inclusion of safety as a responsibility in job descriptions and performance evaluations was identified by all organizations as an area to strengthen.

All organizations have readily accessible corporate health and safety policies and procedures. The policies are located in several manuals. Generally, these are not linked and focus more heavily on patient safety than staff safety and wellness.

All organizations used various tools to communicate safety-related messages including internal newsletters, intranet, safety blitzes, pay stubs and special safety-related bulletins.

Although some organizations have recently added safety as a regular item for management meetings, other organizations are just beginning to include it on the agenda for management and staff meetings.

Discussion of safety-related topics at staff and departmental meetings is episodic and issue-specific.

**Post Implementation Site Visit**

The enthusiasm of senior leaders towards advancing a culture of safety was evident in some organizations. At all sites the commitment of the CEO and other senior leaders was identified by the OH & SC and IC members, managers and staff as a key facilitator to the significant progress they had made in the short time period for this project. All senior teams reported that the entire team was “much more engaged” in advancing a culture of safety and that safety was discussed regularly at senior leadership meetings.
All organizations had reviewed policies and processes to support safety and revised them as needed. In some organizations the number of revised policies was significant. All organizations have developed a system that collates/links all safety-related policies and procedures into one reference resource and includes a process for annual review and updating as needed. The role of the OH & SC in reviewing safety-related policies has been clarified and refined in all organizations.

All organizations provided some dedicated resources to the HSMS project because they recognized the need to assure the timely advancement of the project. Managers and staff were not generally aware of the additional/reallocated resources. However, the OH & SC and IC groups were aware.

All organizations identified the need for a more comprehensive communication strategy to advance the overall safety culture. Some progress had been made at every organization. New approaches included newsletters, poster campaigns, senior leadership walkabouts and senior leadership forums on safety.

At all organizations safety is now a regular agenda item at management meetings. There is an articulated expectation that managers will include safety-related discussions at staff meetings, although staff and managers report that this is still episodic and on an as needed basis. There are more frequent discussions on safety-related matters at both the senior leadership and governance levels.

**INCIDENT REPORTING SYSTEMS/PROCESSES**

**Pre Implementation Site Visit**

All organizations have an incident reporting system and have recently heightened expectations regarding the reporting of “near misses.” All supported a blame-free approach toward incident reporting and follow-up, but indicated that the application of this philosophy is challenging and inconsistent. Timely follow-up is also reported as a “challenge.”

All organizations have existing indicators relating to patient/visitor and staff incidents and injuries which are monitored longitudinally. However, there is no set of common core indicators reported at all organizations or a consistent system for monitoring and reporting. Data regarding patient/visitor incidents is consistently provided to managers, and managers indicated they are responsible for follow-up. The OH & SC at some organizations receive data relative to some types of incidents (e.g., incidents including staff). Data entry and retrieval is variable across organizations.

The OH & SC receives data pertaining to staff accident and injury rates; however, data are not consistently provided to managers. Attendance statistics are the only common data shared with management across all organizations. Staff are generally unaware of safety-related data. The senior leadership team at every organization consistently receives all safety-related data, but the frequency and type of information received varies. All organizations provide some patient and staff safety-related to the governing body at least annually, but there is no consistency in what is reported.

**Post Implementation Site Visit**

All organizations reported they continue to be challenged in advancing a blame-free approach, although some indicated that the OSACH education session entitled “Accident Investigation” is “helping somewhat.” Managers indicated that they had a better understanding of their role in incident investigation and follow-up as a result of the education session. Most organizations reported improvements in their data reporting and sharing during the project, including a review and refinement of existing indicators rather than developing new ones. Any new
indicators that were identified relate to mandatory reporting as defined by the accountability agreement all organizations have with the MOHLTC. Staff accident and injury rates are being more widely shared in a more user friendly format with management and the OH & SC committee. However, staff continue to be unaware of these data.

LEVEL OF UNDERSTANDING OF ROLE AND EDUCATION RELATING TO SAFETY

Pre Implementation Site Visit

All those interviewed articulated a role relating to patient safety in terms such as “patient safety is everyone’s job.” Patient safety was also identified as a requirement included in the standards for most professions. After discussion, staff were able to define a general role in support of staff safety and wellness, but specificity regarding roles was lacking. Managers defined the multiplicity of roles they play relative to both patient and staff safety and the challenge it presents to them. Span of control and competing organizational priorities were cited by managers as their two greatest challenges in advancing a safety agenda.

All those interviewed provided examples of safety-related initiatives and education recently undertaken by their organization. The examples suggest that the focus of education appears to be on mandatory safety-related programs such as fire safety, hand hygiene and safety engineered needle systems. At the staff level there was not a good understanding of the interrelationship between patient and staff safety initiatives or how preventative education programs contribute to the overall culture of organizational safety. All programs appeared to be unique initiatives rather than coordinated into one overarching framework for safety. All identified the greatest challenge as the timely completion of the numerous programs, education fatigue (e.g., information overload), scheduling staff to participate in sessions given staffing challenges and fitting the programs around staff patient/client care responsibilities. Most staff acknowledged the commitment of their organization to try and accommodate these challenges. Managers identified numerous safety-related education sessions they had attended over the years; however, the number of recent presentations attended appeared limited.

Post Implementation Site Visit

All those interviewed continued to articulate a role related to patient safety. The most notable difference was the recognition by staff of their role in terms of their own safety and that of their colleagues. Overall, organizations reported that staff safety and wellness had taken on a “new level of importance” and staff safety was now recognized as “equally important to patient safety.”

Participation in the project allowed some organizations to review the role and responsibilities of the Board of Directors relative to safety and stimulate discussion with the Board regarding its role.

Managers and members of the OH & SC reported the benefit of participation in some of the OSACH education sessions such as Accident Investigation. Some OH & SC members indicated that they have a better understanding and appreciation of their role as a committee member and that the role of the OH & SC is better understood and valued within the organization. Some members also reported a more robust role for the committee relating to monthly inspections and a renewed interest on their part in serving on the committee.
FACILITATORS TO SUPPORT THE HSMS IMPLEMENTATION

Pre Implementation Site Visit

Participants identified a number of common themes that facilitated the implementation of the HSMS within their organization (e.g., safety being explicitly included in the mission, vision, values and strategic directions or priorities of their organization). Staff spoke of the dedication of the senior leadership team towards advancing a culture of organizational safety.

Other facilitators identified by staff included having a stable workforce; granting JHSC members adequate time to attend Joint Health and Safety Committee (JHSC) meetings, complete inspections and follow-up on detected issues; utilizing multiple communication tools to convey safety-related messages including good accessibility to and use of intranets by all staff levels, messages on pay stubs, regular themed safety blitzes and newsletters; and rewarding ongoing skills training and education sessions that emphasize safety is “everyone’s responsibility” and provide staff with the necessary knowledge and skills to safely perform their roles.

Resources to support safety-related initiatives which were identified as “important” included dedicated staff (e.g., safety officer), investment in adequate equipment and providing time for staff to participate in programs. Clear accountability for safety throughout the organization was also defined as a contributing factor. Staff at all levels recognized the importance of a blame-free culture and the use of reporting systems that focus onremediying system/process issues.

Post Implementation Site Visit

There was overwhelming consensus that the commitment of the senior leadership team was critical to the successful advancement of a culture of safety. Demonstrable examples included the commitment of dedicated resources to safety initiatives, active participation of senior leadership on the OH & SC, senior leadership walkabouts, increased time allocation for members of OH & SC members to participate in committee activities, recognition of the work done by the OH &SC, dedicated positions, more time for safety-related education programs and providing replacement time to enable staff to attend sessions. A comprehensive communication strategy that recognizes the learning styles and age spectrum of employees was identified as a key facilitator and one that is still being planned at these organizations. Having current policies and supporting processes was also identified as important.

BARRIERS TO SUCCESSFUL IMPLEMENTATION OF HSMS OR ANY ORGANIZATION WIDE SAFETY PROGRAM

Pre Implementation Site Visit

Barriers across all three organizations were fairly uniform. The theme of adequate time came up repeatedly. Concerns included the time required for organizations to deliver programs, to resolve non urgent safety issues and to schedule staff to attend sessions. Staff admitted that volume of corporate initiatives and competing priorities frequently resulted in them being challenged to “fit everything in” and education fatigue. Staff at all levels identified the challenge of having adequate relief staff to schedule staff to participate, but recognized their organizations’ attempt to rectify this ongoing human resource issue. Another barrier cited was the sustainability of the HSMS given competing priorities, the resources required for robust and meaningful data collection and management and the need for adequate staff and time to implement improvements and initiatives. The logistics of delivering safety programs, especially to a large number of staff, on all shifts and in multiple sites was also identified as a barrier to implementation. Communication and reaching all intended audiences in a timely manner with important safety-related information was the final theme identified at all organizations and by all groups. In particular, engaging medical staff in safety-related initiatives was cited.
Post Implementation Site Visit

There was consensus among participants at all organizations that communication is a key element in advancing a culture of safety and also presents the greatest challenge to reach all of the intended target groups in a meaningful and timely manner. Creating an environment that enables staff to practice safely and participate in education sessions is also a challenge. It is important to encourage a blame-free culture, foster a consistent and positive staff attitude and ensure sustainability of safety-related programs. It is also important to provide readily available, timely and meaningful data to support decision making and demonstrate outcomes.

SURVEY OF PILOT SITE PARTICIPANTS

A survey was sent to all the six sites that participated in the OSACH HSMS pilot project. The survey was designed to gather information on their experience throughout the process. All six pilot sites responded to the survey. When asked if they would recommend the OSACH HSMS to others, 80% responded they would. Participants indicated that the process would be enhanced with further development, clarification and alignment with both WSIB Accreditation Standards and the Canadian Standards Association (CSA) Z1000 standards. The majority (80%) of participants indicated that the level of support from OSACH was good or excellent. They supported the use of the consultant model as it contributed to the achievement of timely outcomes.

When asked to comment about what was good in the HSMS program, the major themes were that the program raises awareness of employee safety, enhances safety culture and provides the impetus for “senior level buy in” and alignment of existing structures toward a common goal and approach to safety and wellness. In terms of improvements, respondents indicated that they would like more training and educational sessions. The major message from participants was that it is important that there is alignment with existing health and safety-related organizations and systems which require data submissions or participation in safety-related processes in order to lessen the strain and workload on organizations. The overall experience with the HSMS program was positive; the majority of participants indicated it was good, very good or excellent. Feedback from the OSACH consultants was positive and included some suggestions for streamlining the HSMS process.

Limitations

This evaluation study has several limitations. The timing and size of the representative groups was an issue. Given the participants’ responsibilities, attendance at pre scheduled focus groups and achieving good representative numbers was a challenge. In addition, some participants had stringent time constraints that did not allow for much in depth discussion in the interviews. Diversity within the sample of organizations was also an issue. Differences in the type, size and number of sites, as well as the governance structure and teaching status of the organizations made comparison of outcomes difficult and somewhat extraneous. Procuring comparable organizational statistics was hampered by a lack of common definitions, data and existing information. The inconsistent sample sizes across the sites and the largely group setting used during the pre and post implementation site interviews may have affected the quality and range of contributions. Finally, it was difficult to measure the long-term impact of HSMS given the short timeframe available for this evaluation.
Conclusion

Limitations aside, all sites indicated that the OSACH HSMS benefited their organizations. Although all organizations involved in the project had significant infrastructure in place before the pilot, each indicated that the program assisted in the development of a more robust infrastructure to support and advance the culture of safety and link staff safety and wellness with patient safety. Thus creating “a more balanced and comprehensive framework for safety at the organization.”

Organizations highlighted that the OSACH HSMS was thorough and highly structured and that participation in the pilot project resulted in more safety-related initiatives than they would have embarked upon on their own. Sites identified many examples of improvements they made during the HSMS pilot project to advance their overall safety program. All believe a program such as the HSMS will contribute to advancing a culture of safety and that staff safety is equally important as patient safety. However, the length of the pilot project did not enable organizations to demonstrate measurable improvements or outcomes. At each site, one rapid cycle improvement initiative was identified and all are in various stages of implementation, but none are completed. Consequently, sites were unable to demonstrate outcomes at this time.

All process evaluation sites identified some key facilitators to advancing a culture of safety: demonstrable commitment by the senior leadership team, clear accountability for safety at all levels of the organization, a clear articulation of safety in the vision and strategic directions of the organization and a comprehensive and current infrastructure to support safety (including policies, procedures, committee structure, educational initiatives, a communication strategy and a framework to measure outcomes). The most notable facilitator echoed by all those interviewed was the demonstrable commitment of senior leadership to advancing staff safety and wellness.

The organizations also identified challenges they experienced in implementing the HSMS. These included the need for a dedicated resource to advance the numerous initiatives identified through the assessment, the time commitment of those involved to ensure timely outputs, accommodating the education sessions within the busy schedules of participants, the ongoing sustainability of the program and the development of meaningful outcome indicators. Sites supported the HSMS as a workable approach to advancing staff safety and wellness and the overall culture of safety.
Recommendations

The following recommendations are made to guide the Ontario Safety Association for Community and Healthcare (OSACH) and assist organizations that adopt the Health and Safety Management System (HSMS) as the framework for advancing staff safety and wellness and the overall culture of safety at their organization.

Infrastructure to Support a Culture of Safety

1. OSACH should continue the use of the HSMS to improve staff safety and wellness and the overall culture of safety in organizations. The approach uses the consultant model to support the delivery of the program. The level of support has to be customized based on unique organizational needs.

2. OSACH should target small to medium size organizations where resources may be more limited.

3. OSACH should encourage participant organizations to do an initial assessment of the following key elements prior to implementation of the HSMS:
   - The vision, mission, values and strategic priorities of the organization clearly articulate the commitment of the organization to patient and staff safety.
   - A communication strategy to ensure safety is “top of mind” for all those involved with the organization. It should maximize the use of technology and accommodate the various learning styles of staff.
   - The safety framework should link all aspects of patient and staff safety and wellness and support a blame-free culture.
   - The safety framework should relate to the existing quality improvement and risk management program.
   - Current safety-related policies and procedures should include a system for regular review and revision.
   - The committee structure should clearly define the accountabilities of committees and relate them to the safety framework.
   - A user friendly and comprehensive incident reporting system which provides timely and meaningful data to the appropriate parties.
   - A clearly articulated governance accountability framework for safety.
   - A corporate scorecard/dashboard which includes safety-related indicators and regular reporting to the board, management and staff. Indicators could include worklife satisfaction, absenteeism/overtime rates, staff injury/accident rates and related claim costs, worker retention rates and NEER assessment rates.

4. Organizations supported by OSACH should develop an overall framework that links all aspects of patient and staff safety and wellness into one comprehensive “picture” of what is included in the organizational vision for safety.
Workforce Planning and Human Resources Considerations

5. Organizations should utilize workforce planning/profiling tools and concepts to plan for adequate staffing to support a culture of safety. *1*

6. Organizations should develop a long-term comprehensive plan to support safety-related programs, preventive education and training programs for staff.

Further Considerations for OSACH

7. OSACH could work with partners such as Accreditation Canada, Quality Management Institute, Canadian Standards Association, Workplace Safety and Insurance Board and others to determine linkages and opportunities to advance staff safety and wellness.

8. OSACH should work with the Canadian Standards Association to validate the HSMS tool as meeting the requirements of the CSA Z1000 through the Quality Management Institute.

9. OSACH could identify exemplars/best practices in employee safety and wellness and create an inventory of best practices for wide distribution. Areas of best practice to consider include communication strategies, recognition systems and advancing a blame-free culture.

10. OSACH should work with others such as the Canadian Institute for Health Information and the Ministry of Health and Long-Term Care to define a common set of data elements with standard definitions, which would be collected at all organizations and demonstrate outcomes for staff safety initiatives and enable comparison across organizations. OSACH should review the indicators contained in pillar 2 of the 5 pillar HSMS program to ensure alignment with this common set of indicators. OSACH could also work with the Quality Management Institute and/or Local Health Integration Networks to advance standardization relating to the collection and analysis of employee safety indicators.

11. OSACH could work with key stakeholders to develop a toolkit which organizations can utilize to build awareness and engage their medical staff in staff safety and wellness initiatives.

12. OSACH could explore opportunities to develop educational materials focusing on staff safety and wellness topics using various media, which could then be provided/marketed to organizations.

13. OSACH could support the development of a longitudinal study that tracks specific indicators and how the HSMS impacted the overall organizational culture of safety.

14. OSACH and/or the participating institutions could also examine the linkage between organizational safety culture and patient outcomes/satisfaction.

References


## APPENDIX A. Data Elements Form Summary

<table>
<thead>
<tr>
<th>Organization Profile</th>
<th>Organization #1</th>
<th>Organization #2</th>
<th>Organization #3</th>
<th>Organization #4</th>
<th>Organization #5</th>
<th>Organization #6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Size of organization (Number of beds)</td>
<td>572</td>
<td>265 (provided much more detail)</td>
<td>208</td>
<td>196</td>
<td>1059 (adult &amp; newborn)</td>
<td>287 (excluding 200 LTC beds)</td>
</tr>
<tr>
<td>Rate Group(s):</td>
<td>Schedule 2</td>
<td>853</td>
<td>853 &amp; 851</td>
<td>853</td>
<td>853</td>
<td>853</td>
</tr>
<tr>
<td>LHIN:</td>
<td>Missisauga-Halton, Hamilton-Niagara-Haldimand-Brant</td>
<td>Toronto Central</td>
<td>Missisauga-Halton, Hamilton-Niagara-Haldimand-Brant</td>
<td>North East</td>
<td>Champlain</td>
<td>Toronto Central</td>
</tr>
<tr>
<td>Type of care: (acute care, long-term care; chronic)</td>
<td>Long-Term care</td>
<td>Acute Care</td>
<td>All</td>
<td>Acute Care</td>
<td>Acute</td>
<td>Rehab &amp; Complex Continuing Care</td>
</tr>
<tr>
<td>Are you going to use a steering committee to oversee the implementation of the HSMS?</td>
<td>Yes</td>
<td>No, using committees and network of project advisors</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>If so, please indicate the positions/depts. that will be invited to participate.</td>
<td>Corporate H&amp;S, CQI/risk mgmt, sr mgmt, JHSC mgmt &amp; worker reps, IC, HR, nursing, dietary, maintenance</td>
<td></td>
<td></td>
<td>Corporate H&amp;S, CQI/risk mgmt, sr mgmt, JHSC mgmt &amp; worker reps, IC, HR, nursing, dietary, maintenance, communications, patient relations, facilities, radiation safety, research</td>
<td>Corporate H&amp;S, CQI/risk mgmt, sr mgmt, JHSC mgmt &amp; worker reps, IC, HR, nursing, dietary, maintenance</td>
<td></td>
</tr>
<tr>
<td>If you are not, please indicate the type of position/ dept. that will be given the primary responsibility.</td>
<td>VP Sponsr – VP HR Also listed – resources</td>
<td>Sr Mgr-facilities, Sr Safety Consultant</td>
<td></td>
<td></td>
<td>No information</td>
<td></td>
</tr>
<tr>
<td>Please provide an organizational chart that describes the reporting structures in the organization.</td>
<td>Provided</td>
<td>Provided</td>
<td>Provided</td>
<td>Provided</td>
<td>Provided</td>
<td>Provided</td>
</tr>
<tr>
<td>Workforce Profile</td>
<td>Organization #1</td>
<td>Organization #2</td>
<td>Organization #3</td>
<td>Organization #4</td>
<td>Organization #5</td>
<td>Organization #6</td>
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<td>----------------</td>
<td>----------------</td>
<td>----------------</td>
<td>----------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Total number of staff</td>
<td>80-3</td>
<td>6495</td>
<td>678</td>
<td>Missing</td>
<td>11,346</td>
<td>858</td>
</tr>
<tr>
<td>Number and percentage of full-time, part time and casual:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Registered Nurses (RNs):</td>
<td>RN-34.8FTE</td>
<td>1011.5FT 289.2PT 2 Casual (54.7 temp)</td>
<td>138FT 102PT</td>
<td>214FT 133PT 14 Casual</td>
<td>1963FT 915PT 573 Casual</td>
<td>150 – 17.2%</td>
</tr>
<tr>
<td>• Registered Practical Nurses (RPNs):</td>
<td>RPN-45.1FTE</td>
<td>90FT 46PT 61 Casual (2 temp)</td>
<td>129FT 87PT</td>
<td>44FT 60PT 1 Casual</td>
<td>93FT 67PT 88 Casual</td>
<td>95 – 10.9%</td>
</tr>
<tr>
<td>• Personal Support Workers (PSWs) or Health Care Aides (HCA):</td>
<td>PSW-261FTE</td>
<td>Nursing specialist 178.2FT 17.5PT (2.3 temp)</td>
<td>32FT 18PT</td>
<td></td>
<td>128FT 79PT 171 Casual (PSW&amp;HCA)</td>
<td>123 – 14.1%</td>
</tr>
</tbody>
</table>

Do you use agency staff? No Yes but not for nursing No Some Yes Yes
Frequency of use? ?? Daily Seldom

How many staff are between the age of 18-25? RN/RPN est 2-5% PSW-est 10-15% 602 91 73 Under 30 – 2,350 34

How many RN retirements over the past 5 years? Data not readily available Nurses & nursing specialists With the abolishment of mandatory retirement, this is not known at this time.

<table>
<thead>
<tr>
<th>Year</th>
<th>RN/RPN</th>
<th>PSW</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>- 4</td>
<td>-</td>
<td>0 N/A 1</td>
</tr>
<tr>
<td>2003</td>
<td>- 7</td>
<td>-</td>
<td>7 24 1</td>
</tr>
<tr>
<td>2004</td>
<td>- 12</td>
<td>-</td>
<td>8 24 0</td>
</tr>
<tr>
<td>2005</td>
<td>- 6</td>
<td>28</td>
<td>13 28 0</td>
</tr>
<tr>
<td>2006</td>
<td>- 10</td>
<td>32</td>
<td>6 29 0</td>
</tr>
<tr>
<td>2007</td>
<td>5 21</td>
<td>6</td>
<td>19 to date 0 to date</td>
</tr>
</tbody>
</table>

How many RNs are 55 years or older? Approx 13 101 Missing 60 Over 60 – 968 46 (includes APN, ACNP)

Vacancy Rate Data to follow Missing Note – yrs are Fiscal Yr Note – yrs are Fiscal Yr 2002=2001-2002

<table>
<thead>
<tr>
<th>Year</th>
<th>RN/RPN</th>
<th>PSW</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>-</td>
<td>-</td>
<td>32.14% -</td>
</tr>
<tr>
<td>2003</td>
<td>-</td>
<td>-</td>
<td>46.96% -</td>
</tr>
<tr>
<td>2004</td>
<td>-</td>
<td>-</td>
<td>43.04% -</td>
</tr>
<tr>
<td>2005</td>
<td>-</td>
<td>-</td>
<td>47.41% -</td>
</tr>
<tr>
<td>2006</td>
<td>-</td>
<td>-</td>
<td>52.82% 1.7</td>
</tr>
<tr>
<td>2007</td>
<td>-</td>
<td>-</td>
<td>58.11% 1.9</td>
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</table>

Absenteeism rate Data to follow Sick days/employee Note – yrs are FY Not available

<table>
<thead>
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<th>Year</th>
<th>RN/RPN</th>
<th>PSW</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>-</td>
<td>-</td>
<td>5.13 -</td>
</tr>
<tr>
<td>2003</td>
<td>-</td>
<td>-</td>
<td>5.21 -</td>
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</table>
### Workforce Profile

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<th>Organization #2</th>
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<th>Organization #4</th>
<th>Organization #5</th>
<th>Organization #6</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>-</td>
<td>5.27</td>
<td>11.2</td>
<td>-</td>
<td>4.44%</td>
<td>-</td>
</tr>
<tr>
<td>2005</td>
<td>-</td>
<td>5.14</td>
<td>10.1</td>
<td>36.8FTE</td>
<td>4.47%</td>
<td>-</td>
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<td>-</td>
<td>5.21</td>
<td>8.8</td>
<td>34.3FTE</td>
<td>4.63%</td>
<td>-</td>
</tr>
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<td>-</td>
<td>3.17</td>
<td>8.7</td>
<td>-</td>
<td>5.2%</td>
<td>-</td>
</tr>
</tbody>
</table>

### Retention/Turnover Rates (HAPS)

- **2005**: Vol – 7.49%
- **2006**: Vol – 7.10%
- **2007**: Annualized Vol – 8.08%

### Staff Overtime Rates (HAPS)

- **2005**: 27.54%
- **2006**: 34.42%
- **2007**: To date 39.12%

### Workplace and Safety Insurance Board Data

<table>
<thead>
<tr>
<th>Schedule 1 or 2:</th>
<th>Organization #1</th>
<th>Organization #2</th>
<th>Organization #3</th>
<th>Organization #4</th>
<th>Organization #5</th>
<th>Organization #6</th>
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</thead>
<tbody>
<tr>
<td>Rebate or Surcharge for:</td>
<td>Schedule 2</td>
<td>Schedule 1</td>
<td>Schedule 1</td>
<td>Schedule 1</td>
<td>Schedule 1</td>
<td>Schedule 1</td>
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<tr>
<td>2002:</td>
<td>-</td>
<td>516,135</td>
<td>-</td>
<td>-</td>
<td>-169,960</td>
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<tr>
<td>2003:</td>
<td>-</td>
<td>677,770</td>
<td>-</td>
<td>-</td>
<td>528,690</td>
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<tr>
<td>2004:</td>
<td>-</td>
<td>692,961</td>
<td>-8,211</td>
<td>-</td>
<td>252,330</td>
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<tr>
<td>2005:</td>
<td>-</td>
<td>76,607</td>
<td>-11.112</td>
<td>Rebate/Surcharge</td>
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<td>Surcharge</td>
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<td>2006:</td>
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<td>778,630</td>
<td>7,617</td>
<td>Rebate</td>
<td>735,150</td>
<td>Surcharge</td>
</tr>
<tr>
<td>2007:</td>
<td>-</td>
<td>-</td>
<td>-42,050</td>
<td>Rebate</td>
<td>-36,200</td>
<td>-</td>
</tr>
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</table>

### NEER performance index for: (HAPS)

- **2002**: Not applicable
- **2003**: Not applicable
- **2004**: 0.071
- **2005**: 0.34
- **2006**: 0.25
- **2007**: 0.73
<table>
<thead>
<tr>
<th>Organization #1</th>
<th>Organization #2</th>
<th>Organization #3</th>
<th>Organization #4</th>
<th>Organization #5</th>
<th>Organization #6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Accident Costs for: (from NEER)</td>
<td>Includes current and previous years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2002:</td>
<td>$106,065</td>
<td>187,693</td>
<td>-</td>
<td>194,385</td>
<td>759,922</td>
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<td>2003:</td>
<td>$81,038</td>
<td>42,830</td>
<td>-</td>
<td>85,988</td>
<td>859,416</td>
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<td>2004:</td>
<td>$98,419</td>
<td>200,143</td>
<td>-</td>
<td>96,482</td>
<td>791,405</td>
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<tr>
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<td>$103,367</td>
<td>63,262</td>
<td>11,583</td>
<td>64,506</td>
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<td>2006:</td>
<td>$131,929</td>
<td>31,274</td>
<td>86,442</td>
<td>98,272</td>
<td>1,367,253</td>
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<td>2007:</td>
<td>$93,564</td>
<td>29,874</td>
<td>-</td>
<td>N/A</td>
<td>210,004</td>
</tr>
<tr>
<td>Top 5 injury trends for:</td>
<td>FY</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2002:</td>
<td>Struck, contact by, over-exertion, struck against, caught in between, slip &amp; trip</td>
<td>Bio, work proc, equip, environ, materials</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>2003:</td>
<td>Struck, contact by, over-exertion, struck against, caught in between, slip &amp; trip</td>
<td>Bio, equip, materials, environ, work proc</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2004:</td>
<td>Struck, contact by, over-exertion, struck against, caught in between, slip &amp; trip</td>
<td>Bio, equip, environ, materials, behave relat</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2005:</td>
<td>Over-exertion, struck, contact by, struck against, caught in between</td>
<td>Bio, equip, environ, materials, work proc</td>
<td>Low back</td>
<td>O/E, Exp, P/A, SACW, P/W</td>
<td>Back/neck, sharps, exp hazard sub/sit, over-exertion/strain (not back/neck), Struck by/contact with</td>
</tr>
<tr>
<td>2006:</td>
<td>Over-exertion, struck, contact by, caught in between, contact with infectious disease, slip &amp; trip</td>
<td>Equip, bio, environ, work proc, materials</td>
<td>Low back</td>
<td>O/E, P/W, P/A, Exp, SACW</td>
<td>Back/neck, sharps, exp hazard sub/sit, over-exertion/strain (not back/neck), Sharps, Patient/visitor action</td>
</tr>
<tr>
<td>2007:</td>
<td>Over-exertion, struck, contact by, caught in between, struck against, slip &amp; trip</td>
<td>Equip, bio, environ, work proc, materials</td>
<td>Upper extremity</td>
<td>O/E, P/A, P/W, Exp, SACW</td>
<td>Back/neck, over-exertion/strain (not back/neck), Sharps, exp hazard sub/sit, slip or fall</td>
</tr>
<tr>
<td>Total Number and Frequency &amp; Severity Rates of Lost Time Claims for: (HAPS) &amp; Frequency</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2002:</td>
<td># - 27</td>
<td>Freq – 7 42</td>
<td>Severity – 89.63</td>
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<td></td>
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<tr>
<td>2003:</td>
<td># - 36</td>
<td>Freq – 0.63</td>
<td>Severity - 16.71</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2004:</td>
<td># - 26</td>
<td>Freq – 2.19</td>
<td>Severity – 123.09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2005:</td>
<td># - 149</td>
<td>Freq – 1.74</td>
<td>Severity – 9.67</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2006:</td>
<td># - 23</td>
<td>Freq – 3.04</td>
<td>Severity – 35.51</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>Organization</td>
<td>Frequency</td>
<td>Severity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>--------------</td>
<td>-----------</td>
<td>----------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2004: # - 24</td>
<td>Freq – 8.61</td>
<td>Severity – 83.68</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2006: # - 40</td>
<td>Freq – 1.85</td>
<td>Severity – 47.73</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2007: # - 51</td>
<td>Freq – 10.65</td>
<td>Severity – 45.96</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Total Number and Frequency & Severity Rates of No Lost Time Claims for: HAPS & Frequency

<table>
<thead>
<tr>
<th>Year</th>
<th>Frequency</th>
<th>Severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002: # - 38</td>
<td>Freq – 0.66</td>
<td></td>
</tr>
<tr>
<td>2003: # - 30</td>
<td>Freq – 0.51</td>
<td></td>
</tr>
<tr>
<td>2004: # - 32</td>
<td>Freq – 0.51</td>
<td></td>
</tr>
<tr>
<td>2005: # - 40</td>
<td>Freq – 0.66</td>
<td></td>
</tr>
<tr>
<td>2006: # - 39</td>
<td>Freq – 0.64</td>
<td></td>
</tr>
<tr>
<td>2007: # - 29</td>
<td>Freq – 7.97</td>
<td></td>
</tr>
</tbody>
</table>

Do you contract out your Occupational/Employer Health Services? No

How many staff are employed in Occupational/Employer Health? 4.5FTE

List positions: 4.5FTE attendance mgt/OHS co-ord CQI/risk mgt mgr OH nurse (0.5) Disability mgt co-ord Disability mgt assist

<table>
<thead>
<tr>
<th>Organization</th>
<th>Frequency</th>
<th>Severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organization #1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Organization #2</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Organization #3</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Organization #4</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Organization #5</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Organization #6</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Recent Initiative Organization Has Been Engaged In</td>
<td>Organization #1</td>
<td>Organization #2</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-----------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Last Chance/ Safe Workplace Partnership Program involvement in past 3 years:</td>
<td>Using MHSA services</td>
<td>No involvement</td>
</tr>
<tr>
<td>2005:</td>
<td>-</td>
<td>No</td>
</tr>
<tr>
<td>2006:</td>
<td>2006, 2007 on MHAS list but NOT on MoL list</td>
<td>No</td>
</tr>
<tr>
<td>2007:</td>
<td>-</td>
<td>No</td>
</tr>
<tr>
<td>Have you had a Ministry of Labour visit(s) in the past 5 years?</td>
<td>No routine visits since 1999 on corporate records MoL called twice by JHSCTe co-chair re mould issues</td>
<td>6 visits</td>
</tr>
<tr>
<td>Have you been a member of a safety group?</td>
<td>Member of CSSE and OMHSRA</td>
<td>No</td>
</tr>
<tr>
<td>If yes, how many years have you been involved?</td>
<td>5 years since 2003</td>
<td>5</td>
</tr>
<tr>
<td>Has Workwell contacted your firm in the last 5 years?</td>
<td>Not applicable as Schedule 2 but planning audit for 3 villages in 2008</td>
<td>No</td>
</tr>
<tr>
<td>Did the contact result in an action plan or a full audit?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome of audit/ action plan?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When was your last Accreditation Canada Accreditation review?</td>
<td>2007</td>
<td>2007</td>
</tr>
<tr>
<td>What was the outcome/rating?</td>
<td>Accreditation with report</td>
<td>3 years</td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


### Table 3  
**Key Indicators for Baseline Data**

<table>
<thead>
<tr>
<th>Employee Health, Safety &amp; Wellness</th>
<th>Organization #1</th>
<th>Organization #2</th>
<th>Organization #3</th>
<th>Organization #4</th>
<th>Organization #5</th>
<th>Organization #6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Work Accommodation Programs – permanent and temporary – per year for:</td>
<td>Data to follow</td>
<td>Permanent accommodations</td>
<td>More effort needed to report further</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2005:</td>
<td>8</td>
<td>22</td>
<td></td>
<td>1,176</td>
<td>14 temp</td>
<td></td>
</tr>
<tr>
<td>2006:</td>
<td>1</td>
<td>19</td>
<td></td>
<td>1,231</td>
<td>3 perm, 23 temp</td>
<td></td>
</tr>
<tr>
<td>2007:</td>
<td>3</td>
<td>25</td>
<td>9/10 perm restrictions 6/6 temp restrictions</td>
<td>1,407</td>
<td>3 perm, 14 temp</td>
<td></td>
</tr>
<tr>
<td>Short-term Disability Rates:</td>
<td>Data to follow</td>
<td>See average sick days (sick days/employee)</td>
<td>Don't know what we're looking for</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2005:</td>
<td></td>
<td>5.14</td>
<td>0.89</td>
<td>669</td>
<td></td>
<td></td>
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<tr>
<td>2006:</td>
<td></td>
<td>5.21</td>
<td>0.71</td>
<td>848</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2007:</td>
<td></td>
<td>3.17</td>
<td>0.62</td>
<td>904</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long-term Disability Rates:</td>
<td>Data to follow</td>
<td># of successful returns for LTD</td>
<td></td>
<td>Cases (FY)</td>
<td>Provided effective dates</td>
<td></td>
</tr>
<tr>
<td>2005:</td>
<td></td>
<td>9</td>
<td>1.1</td>
<td>8 new claims, 6 resolved</td>
<td>47</td>
<td>1.79%</td>
</tr>
<tr>
<td>2006:</td>
<td></td>
<td>13</td>
<td>1.3</td>
<td>7 new claims, 6 resolved</td>
<td>60</td>
<td>1.22%</td>
</tr>
<tr>
<td>2007:</td>
<td></td>
<td>14</td>
<td>0.92</td>
<td>9 new claims, 6 resolved, 1 denied</td>
<td>47</td>
<td>1.36%</td>
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<tr>
<td>Paid Sick Time: (HAPS)</td>
<td>Same as absenteeism rate</td>
<td>Total population</td>
<td></td>
<td>FY</td>
<td>Not available</td>
<td></td>
</tr>
<tr>
<td>2005:</td>
<td></td>
<td>5.11</td>
<td>121.6 days/wk</td>
<td>68,735 hr</td>
<td>-</td>
<td>10.56 d/employee</td>
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<tr>
<td>2006:</td>
<td></td>
<td>5.2</td>
<td>109.7 days/wk</td>
<td>64,034 hr</td>
<td>4.79%</td>
<td>11.4 d/employee</td>
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<tr>
<td>2007:</td>
<td></td>
<td>2.34 yr to date</td>
<td>111.7 days/wk</td>
<td>59,250 hr</td>
<td>5.1%</td>
<td>10.05 d/employee</td>
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<td>Number of training and professional development sessions offered per year: (HAPS)</td>
<td>As costs and by FY</td>
<td>Not available</td>
<td>As $$ and hrs</td>
<td>Not tracked</td>
<td>Not available</td>
<td></td>
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<tr>
<td>2005:</td>
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<td>ADD</td>
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<td>$417,985, 15,258 hr</td>
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<td>2006:</td>
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<td>-</td>
<td>-</td>
<td>$434,429, 14,324 hr</td>
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<tr>
<td>2007:</td>
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<td>-</td>
<td>-</td>
<td>$473,122, 14,404 hr</td>
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<tr>
<td>Attendance:</td>
<td>By type of program</td>
<td>Not available</td>
<td>Missing</td>
<td></td>
<td></td>
<td></td>
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<td>2005:</td>
<td></td>
<td>1270</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>2006:</td>
<td></td>
<td>1458</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<td>2007:</td>
<td></td>
<td>1467</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Patient &amp; Public Safety Data</td>
<td>Organization #1</td>
<td>Organization #2</td>
<td>Organization #3</td>
<td>Organization #4</td>
<td>Organization #5</td>
<td>Organization #6</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>----------------</td>
<td>----------------</td>
<td>----------------</td>
<td>----------------</td>
<td>----------------</td>
<td>----------------</td>
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<tr>
<td>Number of Patient Adverse Events per year for:</td>
<td>Not available to share externally</td>
<td>Not available to share externally</td>
<td></td>
<td>This data not captured at this time</td>
<td>See below</td>
<td>Data not available to share</td>
</tr>
<tr>
<td>2005:</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2006:</td>
<td>-</td>
<td>-</td>
<td>46</td>
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<td>-</td>
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<tr>
<td>2007:</td>
<td>-</td>
<td>-</td>
<td>51</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Number of Patient Sentinel and Critical Events per year for:</td>
<td>Not available to share externally</td>
<td>Not available to share externally</td>
<td></td>
<td>This data not captured at this time</td>
<td>Data not available to share</td>
<td></td>
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<tr>
<td>2005:</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>9</td>
<td>-</td>
</tr>
<tr>
<td>2006:</td>
<td>-</td>
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<td>2</td>
<td>-</td>
<td>8</td>
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<tr>
<td>2007:</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>5 to date</td>
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<tr>
<td>Number of Unusual Occurrence Forms per year for:</td>
<td>Not measured till 2008</td>
<td>not applicable</td>
<td>pending</td>
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<td>FY</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>6084</td>
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<td>2006:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5767</td>
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<tr>
<td>2007:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2764</td>
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<tr>
<td>Number of Patient Complaints per year for:</td>
<td>Not measured till 2008</td>
<td>Pending</td>
<td>No report at this time</td>
<td>Data not available to share</td>
<td></td>
<td></td>
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<tr>
<td>2005:</td>
<td>-</td>
<td>503</td>
<td>-</td>
<td>-</td>
<td>832</td>
<td>-</td>
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<tr>
<td>2006:</td>
<td>-</td>
<td>399</td>
<td>-</td>
<td>-</td>
<td>909</td>
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<tr>
<td>2007:</td>
<td>-</td>
<td>397</td>
<td>-</td>
<td>-</td>
<td>848 to date</td>
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</tr>
<tr>
<td>Number of Public Complaints per year for:</td>
<td>Not measured till 2008</td>
<td>Not tracked separately from patient complaints</td>
<td>pending</td>
<td>No report at this time</td>
<td>Not measured</td>
<td>Data not available to share</td>
</tr>
<tr>
<td>2005:</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<td>2006:</td>
<td>-</td>
<td>-</td>
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<td>-</td>
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<tr>
<td>2007:</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
Thank you for participating in the OSACH Health and Safety Management System (HSMS) pilot project. The research components of the pilot will be concluded by December 31st, 2008. One aspect of the research project is to receive feedback on the Health and Safety Management System and how implementation could be improved for other future participants. We have a brief survey which we ask you to complete by NOVEMBER 14, 2008 to enable us to provide OSACH with timely feedback. Your opinions will be treated as confidential by the research team and summarized for OSACH.

If you have any questions, please do not hesitate to contact Dina Idriss-Wheeler at idrissd@mcmaster.ca or 905-525-9140 ext. 22581.

1. Name of Organization

2. What was your rapid cycle improvement activity?

3. What is the stage of completion?
   - Planned
   - Planned but not started
   - Planned and pilot tested
   - In progress
   - Fully implemented

4. What outcomes have been achieved to date?

5. For future sites, how could the PDCA/rapid cycle improvement aspect of HSMS be changed/improved?

6. Would you recommend the OSACH Health and Safety Management System (HSMS) to others?
   - Yes
   - No
   Please explain why?
OSACH - Survey of Pilot Site Participants

7. Please rate the level of support from OSACH throughout the process:
   - Poor
   - Fair
   - Good
   - Very Good
   - Excellent

   Please comment:

8. What was good about the HSMS program? Process?

9. What should be improved? (HSMS, pillar approach, action plans, reports, education sessions, etc.)

10. Please rate your overall experience with the HSMS Program:
    - Poor
    - Fair
    - Good
    - Very Good
    - Excellent

   Please Comment:

11. Other comments, suggestions, or improvements to the HSMS:

Thank You!

Thank you for participating in this survey. Your input will provide valuable feedback for future enhancements of the HSMS system.
Dear OSACH Consultant,

Thank you for participating in the research portion of the OSACH Health and Safety Management System (HSMS) pilot project. The research components of the pilot will be concluded by December 31st, 2008. One aspect of the research project is to receive feedback from your perspective as a consultant in the process on how implementation could be improved for other future participants.

We would like to allow you to provide input anonymously and request that you complete this short survey by **Thursday Nov 27, 2008**. The results of the survey will not be shared with Pat Norman prior to your one hour session. This session will be an opportunity for further dialogue and comment.

If you have any questions or require further information, please do no hesitate to contact the research coordinator, Dina Idriss-Wheeler at idrissd@mcmaster.ca; 905-525-9140 ext. 22581.

Thank you in advance for taking the time to respond to this survey.

1. From your perspective, rate the benefits for organizations in participating in the OSACH HSMS program?

   - 1 - not at all beneficial
   - 2
   - 3
   - 4
   - 5 - very beneficial

   Please specify:

2. From your perspective, rate the level of difficulty organizations experienced in participating in the OSACH HSMS program?

   - 1 - not at all difficult
   - 2
   - 3
   - 4
   - 5 - very difficult

   Please specify:
OSACH Survey: Consultants

3. From your perspective, rate the level of support organizations expected of the consultant throughout the implementation process?

- 1 - no support
- 2
- 3
- 4
- 5 - extensive support

Please specify:

4. Have any outcomes of the HSMS program have been achieved to date at each organization?

- Yes
- No

Please list examples:

5. Would implementation have been achievable without OSACH support?

- Yes
- No

Please specify:

6. Rate how the education sessions provided supported HSMS and the rapid cycle improvement initiative.

- 1 - not at all beneficial
- 2
- 3
- 4
- 5 - very beneficial

Please specify:

7. How could the education sessions be improved?
OSACH Survey: Consultants

8. A specific improvement activity was identified during the HSMS process at each organization and an action plan developed.

Did HSMS assist in

<table>
<thead>
<tr>
<th></th>
<th>not at all</th>
<th>Occasionally</th>
<th>Extensively</th>
</tr>
</thead>
<tbody>
<tr>
<td>Defining the activity?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Planning and implementing the action plan?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Defining and monitoring indicators?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9. For future sites, what should be improved? (Check ALL that apply)

- HSMS program overall
- Pillar approach
- Consultant process evaluation logs
- Action Plan
- Other aspects of program

Please provide an explanation:

10. Other comments/suggestions:
APPENDIX C. Data Collection Tool - Interview Questions

Nursing Health Services Research Unit

ONTARIO SAFETY ASSOCIATION FOR COMMUNITY AND HEALTHCARE (OSACH)

HEALTH AND SAFETY MANAGEMENT SYSTEM EVALUATION

Pre and Post Implementation Interview Guide

Organization:

Participant Group:

Number of Participants in Interview:

Dates Held:

1. Describe your understanding of the OSACH Health and Safety Management System (HSMS):
   
   (For Senior Leadership): Why did your Organization get involved?

2. Do you have a clear understanding of the OSACH HSMS program which will be implemented over the next year at your organization?
   
   Describe briefly:

3. Do you have a clear understanding of what is expected of you throughout the upcoming implementation process?

4. What do you think are the barriers to implementation of HSMS at your organization?

5. What do you think are the facilitators to implementation of HSMS at your organization?

6. What policies on safety, health and wellness do you have in your organization?
   
   (For Senior Leadership, Management and Joint Health & Safety Committee): Is safety a documented strategic priority included in the strategic plan?

7. Is there a corporate policy on health and safety?

8. How is it communicated to staff?
9. How do you know that your organization is committed to a culture of safety?

   Do you have readily available policies?
   Is safety discussed regularly at staff/leadership/committee meetings?
   Is safety included in position guides?
   Is safety included in performance evaluations?
   Joint Health and Safety Committee?
   Other safety-related committees?
   A blame-free culture to encourage incident reporting?
   Other examples:

10. Do you know your internal responsibility system related to health and safety in your organization?

   Steering Committee/JOHSC: yes, there are a lot of committees involved in safety e.g. JOHSC, patient safety, etc. Patient safety and staff safety are two distinct areas

11. Is the internal responsibility system functional?

12. What safety-related data are shared throughout the organization?

   Patient/visitor incidents? With whom?
   Staff accident and injury rates? With whom?
   Attendance statistics? With whom?
   Other statistics: list

13. Do you understand your role in health and safety?

   Describe your role:

   (For Management Focus Group): As a manager, how are you involved in monitoring employee compliance with health and safety policies and procedures?

14. What type of training and education specific to health and safety have you received in the past year?

15. Do you know who your Joint Health & Safety Committee representative is?

16. Are monthly safety inspections conducted in the workplace?

17. What type of preventive programs do you have in place? List

18. What are the overall challenges relating to safety, health and wellness in your organization?

19. Other comments regarding health and safety

20. (For Senior Leadership): What mechanism do you have in place to monitor measure and investigate the health and safety program?
APPENDIX D. Review of Consultant Logs and Action Plans by Research Manager

Review of two action plans indicated a partial overall compliance level for each organization in terms of the statements relating to each pillar. Each organization has defined a very aggressive plan to achieve full compliance on the majority of the statements by the end of 2008.

A review of the updated action plans indicated that the organizations made the decision to pursue many more actionable items that was anticipated by OSACH, and during the life of the pilot project they achieved full compliance with most of the elements of each pillar. The rapid cycle improvement initiative at the organizations appeared to be broad and complex (e.g., workplace violence). Consequently, the improvement initiative was not completed during the pilot project timeline. In retrospect, it would have been helpful for the organizations to further refine the project to achieve an outcome during the pilot.
APPENDIX E. Site Profiles

The following outlines the profile of the three organizations involved in the process evaluation.

<table>
<thead>
<tr>
<th></th>
<th>The Ottawa Hospital</th>
<th>West Park Healthcare Centre</th>
<th>Halton Region Services for Seniors Division</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td>Ottawa</td>
<td>Toronto</td>
<td>Halton</td>
</tr>
<tr>
<td>Local Health Integration Network (LHIN)</td>
<td>Champlain</td>
<td>Toronto Central</td>
<td>Missisauga-Halton, Hamilton-Niagara- Haldimand-Brant</td>
</tr>
<tr>
<td>Classification</td>
<td>Academic Health Science Centre</td>
<td>Rehabilitation &amp; Complex Continuing Care (CCC) and Long Term Care</td>
<td>Long Term Care</td>
</tr>
<tr>
<td>Governance</td>
<td>Public Hospitals Act</td>
<td>Public Hospitals Act</td>
<td>Municipal Act</td>
</tr>
<tr>
<td>Number of Sites</td>
<td>3 sites</td>
<td>1 campus</td>
<td>3 LTC Homes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(4 buildings)</td>
<td>2 Adult Day Program Sites</td>
</tr>
<tr>
<td>Bed Capacity</td>
<td>963 Adult</td>
<td>133 Rehabilitation</td>
<td>572 Long-term care</td>
</tr>
<tr>
<td></td>
<td>96 Bassinets</td>
<td>154 CCC</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>200 Long-term care</td>
<td></td>
</tr>
<tr>
<td>Is employee wellness/safety explicit in the values of the organization?</td>
<td>“Create enabling environments” (staff wellness)</td>
<td>“For safer care, stay aware – We all have a role to play in safety”</td>
<td>Staff wellness is a strategic direction</td>
</tr>
<tr>
<td>Staff (FTE’s) – FT/PT ratio</td>
<td>2,184 FTE</td>
<td>666 FTE</td>
<td>495 FTE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Excludes LTC FTE’s</td>
<td></td>
</tr>
<tr>
<td>Number of Staff in Safety Department</td>
<td>35.6 FTE</td>
<td>6 FTE</td>
<td>4.5 FTE</td>
</tr>
<tr>
<td>Occupational Health &amp; Safety Committee</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Committee Structure</td>
<td>Patient Safety</td>
<td>Yes – combined with Quality</td>
<td>Yes – combined with Quality</td>
</tr>
<tr>
<td></td>
<td>Joint Occupational Health &amp; Safety</td>
<td>Yes – combined with Quality</td>
<td></td>
</tr>
<tr>
<td>Safety Inspections</td>
<td>Frequency</td>
<td>Monthly</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td>Participants</td>
<td>Managers, Occupational Health &amp; Safety Committee members</td>
<td>Managers, Occupational Health &amp; Safety Committee members</td>
</tr>
<tr>
<td>HSMS Implementation committee</td>
<td>Site specific or corporate</td>
<td>Corporate</td>
<td>Corporate and site specific</td>
</tr>
<tr>
<td></td>
<td>Existing or New committee</td>
<td>New</td>
<td>Existing, membership augmented</td>
</tr>
<tr>
<td></td>
<td>Membership</td>
<td>Includes senior management, management, staff, union</td>
<td>Includes senior management, management, staff, union</td>
</tr>
<tr>
<td>Safety Officer (dedicated/shared)</td>
<td>Dedicated</td>
<td>Dedicated</td>
<td>Dedicated (recently hired)</td>
</tr>
<tr>
<td>Innovative Approaches</td>
<td>Virtual Safety Institute</td>
<td></td>
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</tbody>
</table>
SPECIFIC INFORMATION REGARDING THE ORGANIZATIONS

HALTON REGION SERVICES FOR SENIORS DIVISION

Halton is a large, high population growth area located to the west and north west of Toronto. The population is expected to increase from 375,000 in 2001 to 592,000 by 2021 (Senior Leadership Representative, Halton Region, personal communication, October 22, 2008). It is part of the Mississauga-Halton and Hamilton-Niagara-Haldimand-Brant Local Health Integration Networks.

The Halton Services for Seniors Division is accountable to the Social and Community Services Department, Halton Region. The region owns and operates three long-term care homes (a total of 572 long-term care beds) plus two adult day and other programs (e.g., supportive housing for seniors). This multi site organization has grown quickly over the past three years, and the different sites are at various stages of preparedness regarding their safety programs. The sites are governed by the Municipal Act and Long-Term Care Act which report to the MOHLTC. The division is large and has 800 (495 FTE) employees. Due to its size, it has a divisional structure for quality and safety, which differs from other divisions in the region that rely on the regional safety program. An annual update is provided to Halton Regional Council members, who are elected officials and provide the governance role.

There is a divisional Joint Health and Safety Committee and three site-specific committees at each of the long-term care homes. Recently, two dedicated positions have been added to support quality, risk and health and safety. The implementation committee for this pilot project was primarily the senior leadership team. The Manager for CQI and Risk led the project. The division decided to participate in the HSMS program in order to extend the culture of safety to staff. Several years earlier they increased emphasis on resident safety, but staff safety lagged behind.

During the pre implementation site visit, all interviewees agreed that resident safety programs were more developed than the staff safety initiatives. At the post implementation site visit, senior leadership, management, the implementation committee and Joint Health and Safety Committee members agreed that the culture of safety had advanced markedly in a short period. It was identified that the focus of activities has been on building the infrastructure to support advancing the culture of safety, and the division was about to roll out programs to staff. Staff did not indicate an awareness of the changes yet, which supported the responses of other groups regarding timing of their efforts.

The rapid cycle improvement project undertaken was the management of musculoskeletal disorders and focused specifically on safe patient lifting. It included a review of existing processes, development of new policies, the identification of a pilot test group, development of an education program for staff and the identification of outcome indicators. The project is scheduled for pilot testing at one site in November, 2008.

Other changes which occurred during the pilot included the following:

- Education for management regarding incident investigation and follow-up. Anecdotally, managers believe the timeliness of follow-up and documentation has improved.

- Education for registered staff on how to complete the staff incident forms in order to obtain better data.

- Significant enhancements to the role of the site-specific OH & SC. These included more time and resources for the committees, improved data for their review, a revised role relating to review of new and existing policies and procedures and time for proactive discussion regarding staff safety-related matters).
A Pilot Project to Evaluate the HSMS by OSACH

- Development of a comprehensive indicator reporting system and initiation of the Quality/Safety Council.
- Monthly senior leadership walkabouts at various sites.
- Total review of existing safety-related policies and revision to many, plus the development of new policies where gaps existed.
- Introduction of new communication strategies including the use of colour coded communication sheets and communication binders. An overarching Communication Plan is in development which will include a greater emphasis on safety for all (i.e., residents, families and staff).
- Greater emphasis on safety at all management and team meetings. Safety is now being included in job postings and performance appraisals and the intent is to place greater emphasis on it in the future.

Overall the division believes that the HSMS provided both an infrastructure to advance the culture of safety and a framework to sustain the initiatives. They acknowledged “their journey is just beginning,” but the progress since the inception of HSMS is significant.

WEST PARK HEALTHCARE CENTRE

West Park Healthcare Centre is a single site specialty rehabilitation and long-term care facility located in the west end of Toronto. It is governed by the Public Hospitals Act and has its own governance structure and Board. It is also accountable to the Central Toronto LHIN. West Park Healthcare Centre has 133 rehabilitation, 154 complex continuing care and 200 long-term care beds on the campus. Due to the populations served, the organization experiences some unique safety issues (e.g., scooter safety). There are 858 staff members.

The organization has a Joint Occupational Health and Safety Committee, which served as the Implementation Committee for the HSMS project. The CEO visited the committee during the project to lend support. The Vice President, Corporate and Support Services, led the project and was supported by the Director of Human Resources.

West Park Healthcare Centre volunteered to be one of the six pilot sites for project because they had concerns about their rising rate of musculoskeletal injuries for staff. They believed it would provide them with a structure to address this issue systematically and foster a greater culture of safety that links patient safety with staff safety.

During the pre implementation site visit, all interviewees indicated that the emphasis within the organization had been on patient safety and that staff safety had lagged behind. Staff safety initiatives were fragmented and operated in silos. Data availability was reasonable, but it was not as well used as possible. There were numerous policies, but the process for consistent, timely and regular review required formalization.

During the post implementation site visit, senior leadership and the Implementation Committee identified the significant progress they had made in ensuring a balance between patient and staff safety. They perceived that the two were now recognized as equally important. The work of the Safety Officer and Occupational Health and Safety staff was interfaced and “silo mentality” was reduced. All interviewees identified the contribution these staff and departments make to the overall culture of safety. Staff at all levels had an awareness of OSACH and there was increased attention to safety within the organization.

The rapid cycle improvement initiative was related to reducing the incidence of musculoskeletal disorders among staff through education programs on proper lifting and moving processes.
The policies to support the initiative are in the final approval stage. An education package has been developed and the department has been identified to pilot test the new system (i.e., Food Services). The project will begin in November 2008 and will be evaluated before it is extended. There is a concern about having ongoing resources to support the program organization wide. Indicators have been developed to track progress.

Other changes which occurred during the HSMS pilot included the following:

- All safety-related policies were reviewed and updated and new ones developed as needed. The annual review process was refined and a schedule for review developed. The role of the Joint Occupational Health and Safety Committee in policy review was modified to ensure timely input prior to approval.

- Training sessions for managers and registered nurses relating to accidental investigation and follow-up were enhanced.

- A new semiannual report to the Board was defined and enhanced discussion at the governance level relating to safety occurred.

- The introduction of two new indicators relating to staff incidents.

- Monthly inspection process and follow-up was streamlined.

- A new communication strategy relating to safety for all was introduced and has increased awareness that “we all have a role to play in safety.”

- Greater awareness and enhanced commitment by all staff regarding their role in advancing patient and staff safety.

- Safety is recognized as important by all.

- Patient safety weeks, walkabouts by senior team and monthly departmental discussions with the CEO relating to safety.

Overall, the organization believes that the HSMS enabled them to make significant progress in advancing a culture of safety, which they otherwise could not have achieved had they not participated. The commitment of senior leadership towards this initiative was identified as a key contributor to the progress made. The role of the safety officer and the work of occupational health and safety team are “valued.” Staff in these teams appear “invigorated” by the enhanced recognition and processes.

THE OTTAWA HOSPITAL

The Ottawa Hospital is a large multi-site academic health science centre located in Ottawa, Ontario. There are three acute care sites spread across the city. Each site and department is at varying stages of readiness for safety programs. The organization is governed by the Public Hospitals Act and has its own governance structure and Board. It is also accountable to the Champlain LHIN. There are a total of 963 adult beds and 96 bassinets at the sites. There are more than 12,000 staff (2184 FTE) plus medical staff with privileges and rotating medical students and fellows. The organization provides services in both official languages.

The committee structure to support safety includes a corporate Health and Safety Committee and three site-specific Joint Health Safety committees. An Implementation Committee was established to lead the pilot project and was accountable to senior leadership through the Vice President of Facilities, Planning and Support Services. The Senior Vice President of Human Resources, who is responsible for health and safety management for the organization and the
Director of Occupational Health, Safety and Emergency Preparedness championed the project and provided regular reports to the senior leadership team. The Ottawa Hospital sought out OSACH for a safety-related system that would support their organization's commitment to advance the culture of safety overall.

During the pre implementation site visit, interviewees indicated that the emphasis within the organization had been on patient and staff safety-related initiatives for a period of time. Challenges included communication and consistent messaging in such a large organization, aligning improvement initiatives with corporate priorities and finding ways to deliver education programs to a large and diverse staff. Often the greatest challenge was freeing front line staff to enable participation. Technology is used to deliver some programs. Data availability was reasonable and available for management, but it was not as well used as possible. There were numerous policies, but there was not a consistent process for regular and timely review. The incidence of workplace violence was being reported more frequently and the organization wanted to address and reverse this trend.

During the post implementation site visit, the Implementation Committee identified the progress they had made by using the pillar assessment process to identify gaps and an action plan to address the gaps in their internal health and safety systems. Gaps included the environment, equipment maintenance processes, communication strategy, data integrity and dissemination and training needs for staff. Through this process, a review of safety-related policies occurred and the process for annual review was improved. The work of the Occupational Health and Safety division was better integrated, collaboration within the team was enhanced and duplication of effort was reduced. Staff at all levels identified the organization's commitment to support staff and provide a safe work environment. Much of the discussion focused on the rapid cycle improvement initiative related to workplace violence.

The rapid cycle improvement initiative related to reducing violence in the workplace is only beginning. A standing committee has been established to lead the planning and implementation. The focus to date has been on delivering the critical incident training program to all staff in high risk areas. The response rate has been excellent in the mental health program and is just beginning in the maternal newborn program. A plan for annual recertification is being developed to ensure the ongoing knowledge needs of staff are being met. A challenge has been finding staff replacements to enable staff to attend the education session. Staff in the mental health program identified other changes that had been made to their unique areas to assist in keeping staff safe. The maternal newborn program was only recently identified as a high risk area and activities are only beginning for this group of staff.

Other changes which occurred during the HSMS pilot included the following:

- Management reported that information on staff incidents is being provided in a more user friendly format.
- More discussion at management meetings on safety.
- Increased awareness by all staff of the importance of safety.
- Regular attendance by the Director of Occupational Health and Safety at senior management meetings for support of initiatives and information sharing/discussion/corporate direction.

Overall the organization is strategically committed to advancing a safety agenda. They have a well developed infrastructure in place and the HSMS has assisted in enhancing it.