CASE STUDY: SEVEN OAKS GENERAL HOSPITAL[1]

by

N. Sue Bruning, Ph.D.
University of Manitoba

This case study summarizes the development of Seven Oaks General Hospital and the hospital's approach to employee safety, health and wellness. The history of the hospital and the Wellness Institute are provided. The focus of the case is on a middle manager's decision-making role in deciding upon a strategy to integrate two approaches to health and safety and the wellness initiatives currently practiced in the hospital.

Lisa Habner, Director of Rehabilitation Services, has just come back from a meeting with Carolyn Steiner, Chief Operating Officer of Seven Oaks General Hospital. Her mind swims with the challenges that are facing her as she has been asked to coordinate a new integrated strategy between the health and safety functions of the hospital and the established wellness initiatives. Wellness and health and safety are both significant parts of Seven Oaks General Hospital's overall organizational strategy. The Healthy Organization committee is an outgrowth of a previous Organizational Development committee that has recently been disbanded due to a strategic review during the summer of 2005. The overall summary of the review process indicated that the committee was too broad-based to effectively carry out a focused and integrated wellness and health and safety strategy.

Context

In the 1960s the northern part of Winnipeg (frequently termed the North End) was left without a hospital. St. Joseph's Hospital had been closed and the Children's Hospital had been moved to another location in the city. In the late 60s and early 70s a city councilor, Olga Fuga, and a number of north end activists, Joe Zuken, Abe Yanfosky and Saul Miller, began lobbying the city and Manitoba provincial governments for a hospital to be located in the north end of the city. Years passed as the organizers met with consecutive governments to gain momentum for the new hospital. Incremental progress was made as one government gave land, another gave permission to build, and decisions

[1] This project was funded by Minerva SAFE Manitoba through the Worker's Compensation Board of Manitoba. A previous version of this case was presented at the Administrative Sciences Association of Canada 2006 Annual Meetings, Banff, AB, June 3-6, 2006.

were made to support a hospital in the area rather than a clinic. Residents of the area felt a strong need for the hospital and added their voices to presentations to the governments. In 1981 the dream was realized with the completion of Seven Oaks General Hospital (SOGH), an innovatively designed acute patient care facility. Hexagon units, where rooms surrounded a nursing station, were built in the place of traditional long hallways. The hexagon design was adopted in order to provide a more personable connection between patients and care providers (Positively Healthy, 2006).

The mid 1990s brought new challenges to the hospital as the Manitoba government grappled with reduced transfer payments from the federal government and staffing cuts were mandated by the provincial government. In late 1994 a plan to close the Emergency Department at SOGH was proposed as a way to cut back on Winnipeg's hospital services. Since three quarters of the admissions at SOGH originated from Emergency Room admissions, this decision would have had a strong ripple effect throughout the hospital and it's other services. With the support of the hospital unions, community members, the hospital Board, and Olga Fuga (Board Chair), the Manitoba government eventually decided to keep the Emergency Room open and the hospital was also able to retain the acute care programs and services that were offered at the time (Positively Healthy, 2006). Currently SOGH operates as a 275 bed acute care facility and offers a wide range of services including programs and services in medicine, surgery, ambulatory care, rehab/geriatrics, critical care, mental health, asthma care, spiritual care, hearing, and dental. The SOGH also operates the Kildonan Medical Centre. Five unions, combined, represent approximately 75 percent of the work force. Approximately 75% of the employees are represented by the Manitoba Nurses' Union and 90% of the employees are female (Lamontagne, 2002). SOGH was selected as one of the Maclean's List of Canada's Top 100 Employers in 2004 and 2005, and was also named one of the Best Employers for 50 Plus Canadians in 2005. SOGH employs over 1300 staff in various roles within the organization. The following table summarizes the SOGH Workload statistics for 2004-05 and for 2005-06:

SOGH Workload Statistics	**2004/05**	**2005/06**
Admissions	5,635	5,672
Patient Days	103,003	103,219
Occupancy Rate	96.3%	96.5%
Emergency Visits	33,822	35,444
Surgical Operations	6,301	6,316
Oncology Visits	1,913	2,134
Dialysis Treatments	22,155	26,138
Laboratory Units	2,587,156	2,591,448
X-ray Exams	32,671	33,543
Ultrasound Exams	6,667	6,563
CT Exams	6,238	6,613
Nuclear Medicine Exams	1,933	1,871
Electrocardiograph Exams	4,258	4,077
Volunteer Hours	30,902	30,132

Source: Finance Department, September, 2006

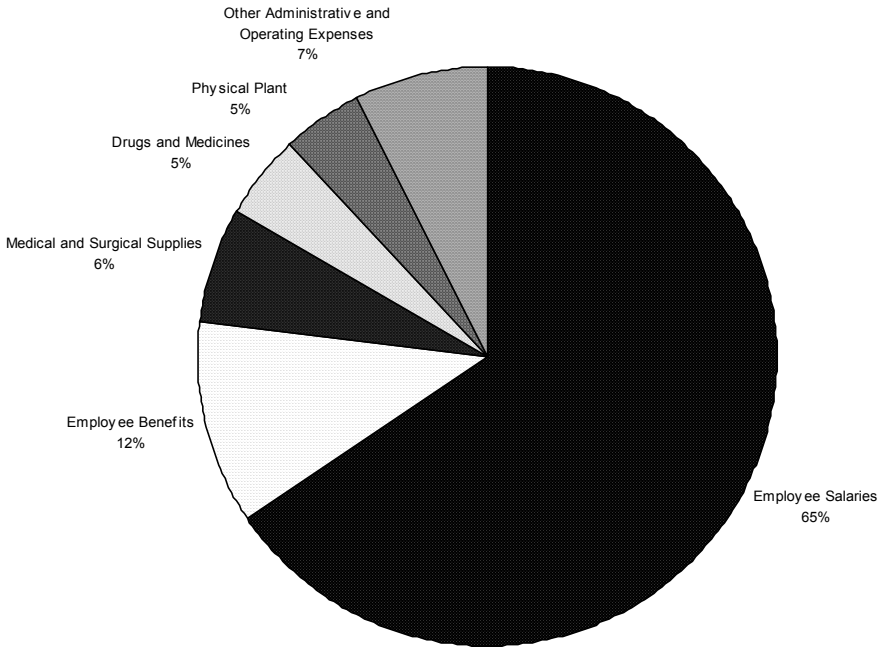
David Brown, Chief Executive Officer of SOGH, is reported to be a visionary leader who has positioned SOGH as a facility that is not only an acute care facility but one that emphasizes preventative approaches to health problems. He laments the fact that hospitals in Canada have rarely taken on the preventative role which is seen by proponents to be a means to reduce medical costs. He lead a strategic planning team to reassess the Values, Mission and Vision of SOGH. The new set of values, mission and vision (see Exhibit A) came out of the four pillars of an organizational development strategy:

- A healthy work organization culture
- Promotion of holistic wellbeing through an increase in personal responsibility and programs for staff
- Providing a safe and healthy work environment
- Supporting balance between work, personal and community life.

David strongly believes that creating a healthier workplace is critical to providing better patient care. This basic premise is incorporated into the values statements and serves as guidance to the organizational development philosophy of the hospital.

Operating Statistics and Organizational Structure

The total operating budget for SOGH is just over $70 million a year. The following pie chart demonstrates how the expenditures are allocated:



❑ Employee Salaries	$46,704,796
❑Employee Benefits	8,254,257
❑Medical and Surgical Supplies	4,591,550
❑Drugs and Medicines	3,632,516
❑Physical Plant	3,236,606
❑Other Administrative and Operating Expenses	5,341,773
❑TOTAL EXPENDITURES	**$71,761,498**
❑TOTAL REVENUE	**$70,689,802**

The organization structure of the hospital is presented in Exhibit C. The hospital is organized into five divisions, managed by five Chiefs of the divisions. They are the Chief Medical Officer, Chief Nursing Officer, Chief Finance Officer, Chief Human Resource Officer and the Chief Operating Officer. The various functions that fall under each "Chiefs" responsibility are represented in the chart.

The Development of the Wellness Institute

From the beginning, wellness was a strong emphasis at SOGH. The act of Incorporation in 1970, specifically spells out the focus of the hospital's strategy, "(to) promote the general health of the community". Community was defined as the employees as well as the patients and other members of the surrounding area. Shortly after the hospital opened a small fitness centre, the Joseph Zuken Fitness Centre opened and was operated by the City of Winnipeg Recreation Department. Staff and patients used the facility and it began to play a role in rehabilitation programming for the hospital. Seven Oaks staff soon realized the need for a more comprehensive medical fitness centre that focused on both the needs of the staff and the community. A planning team conducted a community needs assessment and reviewed facilities in other communities, particularly in the U.S. where medical fitness centres were more common. The Wellness Institute (WI) was born out of that assessment process and opened it's doors in 1996 as the first medical fitness centre owned and operated by a hospital in Canada. Over $11 million in funds to build the facility were raised by community fundraising efforts and allocations from the SOGH Board from their Ancillary funds. The WI operates as a self-supporting non-profit department of SOGH. A number of general principles guide the operations of the WI. The intent of the WI is to ensure that the facility:

- Includes exterior space that is designed to function as usefully as the interior;
- Is accessible and useable but controlled in a manner appropriate for a cost-recovery operation;
- Can accommodate member usage that varies from peaks to lows, may grow over time, and is prompted by changing interests over time;

- Reflects the concept of sustainable development;
- Has a healthy indoor environment and ergonomically correct furniture and equipment;
- Exudes a sense of holistic wellness not only physical fitness;
- Accommodates all ages;
- Can be economically maintained at high standards of cleanliness and functionality.

The WI provides numerous programs to staff, patients and community members. Recent programs included a large variety of offerings covering a diverse set of wellness topics including:

- programs for individuals living with a chronic diseases
- risk factor reduction programs focused on healthy weight management, nutrition, and smoking
- lifestyle change programs that offer strategies for making and sustaining lifestyle changes
- diabetes education classes provide information on control of blood sugars
- social wellness programs to facilitate social interactions amongst groups of people with similar interests
- CPR and First Aid classes
- general courses are offered to educate participants on various types of diseases and approaches to maintaining health
- meditation and relaxation courses
- classes on self-improvement and self-care, e.g., gambling awareness, laughter
- emotional well-being classes include topics such as anxiety disorders, meditation music, positive thinking, cognitive therapy, anger management, spiritual responses to anxiety, anxiety disorders and addictions
- support groups for people living with chronic conditions
- spiritual exploration classes with topics such as yoga, and spirituality and depression
- women's health issues such as menopause, and women and depression
- parenting classes with topics on babies, addictions concerns, mood disorders in children and adolescents and anger management for teens
- gardening
- tiny tots, kids and teen programs
- karate and dance classes
- adult fitness classes and active older adults classes
- Pilates classes

There are over 6000 members of the WI and the programs and facilities resulted in 304,066 member visits during the 2004-05 fiscal year. Recent renovations will enlarge the space to accommodate more popular programs and provide more separation for incongruent activities, e.g., quiet reflective activities and those that lead to high noise levels.

The WI is managed by Carolyn. Her title, Chief Operating Officer, and position as part of the Executive management team exemplifies the strong role that wellness plays in SOGH's strategic plan and operations. In addition to the direction of the WI, Carolyn is also responsible for corporate planning for the hospital, the pharmacy, cardio/ respiratory, organizational development, and general governance structures within the hospital. One of the primary strategic directions that she supports in the hospital is a more central and integrated role of wellness. A new organization structure for the WI was adopted in October, 2005 (Exhibit B).

The Health and Safety Function at SOGH

One of the functions of the original fitness centre and the WI was to promote the wellness of the SOGH staff. The health and safety function of the hospital evolved separately and focused on a number of basic health and safety issues. Health and safety committees operate at unit levels and recommend equipment and training needs to address various safety concerns, e.g., exposure to infectious diseases, proper lifting and transferring of patients, proper equipment operation, etc. The Workplace Health and Safety Committee, as required by provincial legislation, includes members from labour as well as supervisory and professional personnel.

In early 2003, SOGH, along with a number of other Winnipeg hospitals, after inspections from Manitoba Labour and Immigration, Workplace Safety and Health Division (WSH) was issued two broad-based Improvement Orders. These orders identified a number of unsafe practices and together provided 20 areas that needed attention. First and foremost was the lack of a comprehensive and coherent workplace safety and health plan. The Workplace Safety and Health Program must include 11 elements as specified in provincial legislation and the Improvement Order and Report Form (see Exhibit D). A second improvement order listed 19 areas of health and safety hazards and non-compliance. They included problems in areas of documentation, policies and practices that were needed to ensure safe and healthy work practices (see Exhibit E). As a response to the Improvement Orders, SOGH began work on improving the organization's safety and health practices. To date, SOGH has made significant progress on addressing some of the Improvement Orders:

1. They have adopted a **Workplace Health & Safety Policy Statement** which specifies the overall intent of the hospital to maintain a healthy and safe work environment for individuals who visit or work in the hospital in some capacity. Elements of the Workplace Safety & Health program are specified and the responsibilities of the Chief Executive Officer, directors/managers/supervisors, management safety representative, employees and workplace safety & health committee members are identified.
2. A policy on **Worker Involvement** that sets out guidelines to ensure workers are involved in the safety and health functions of the hospital.
3. A **workers and supervisors safety and health training program** has been established with guidelines about the structure of the program.

4. A policy was established on how **investigations** should be carried out
5. A number of policies were established to deal with particular improvement orders, i.e., lock-out/tag-out policy, and eyewash equipment.

An innovative approach to addressing one of the highest areas of worker's compensation claims (lifts and transfers) was the STAR (Safe Transfer Area Representatives) program. This program was initiated out of the safety and health committee discussions as a way to address injuries related to lifts and transfers of patients. Health care aides were identified as a group that tended to perform very basic tasks and lacked empowerment in the patient care hierarchy. Groups of aides were provided further training with proper lift and transfer procedures. They then assisted others on their work units in proper lift and transfer techniques. They have also been tasked to observe lifts and transfers on their units and identify those who are following improper procedures. Reports on the program indicate high levels of satisfaction by the aides and reports that they are experiencing more meaning in their work and a greater sense of empowerment. Given the success of the STAR program, this initiative is seen by many as a model to improve other areas of safety and health practices.

The health and safety function of the hospital has been managed by the Human Resource (HR) Department and coordinated by a small group of individuals in HR. The Chief Human Resource Officer, Tristan Walker, provides the general oversight of the Safety and Health function. The occupational health nurse, Janice Cleverly, collects and analyses the statistics from the Workers Compensation Board, maintains records on injured workers, and works with individuals who have been injured at work to ensure a safe return to work. To date, little of the workers injury/accident and compensation data has been used to assess the effectiveness of various health and safety interventions. Janice feels that her primary responsibilities are to specific health and safety needs. She is partly responsible for the injured worker's program and is the case manager for the Workers Compensation Board, and is responsible to help workers return to work as soon as possible after and accident or injury. She works closely with Denise Boyd in Educational Services to identify training needs and with Patrick Jung on the Workplace Health and Safety Committee (WSH Com). Denise identifies a number of areas where she works with WI staff, e.g., the injured workers program, making referrals to the WI for their services, the lifts and transfer program, the ergonomics program, and workplace wellness teams. Janice views health and safety and wellness as dealing with two very different sets of issues. The WSH Com should work on "issues that are brought to the table" and staff concerns. The committee's primary responsibilities are to make recommendations about how to deal with the issues. Wellness, in Janice's view, should focus on the promotion of general employee health and well-being.

Denise Boyd, the Manager of Educational Services, is in charge of the education/training for the entire staff. These programs include mandated/legislated programs as well as unit specific programs, for example in the power plant or clinical areas. An example of a clinical program would be annual CPR certification, another would be the use of external defibrillators. She works with managers to identify education/training needs. One of the new program areas has been how to handle difficult

or abusive patients. These programs also include disability management and the injured workers program. Denise indicated in interviews that she is currently working on a database system to identify mandatory training that each employee is required to take and when the person is due for a refresher course. The database will also aid in the planning of programs since it will alert the education services area when a critical mass, e.g., 15 people are due for particular training. Employees who don't attend scheduled and mandatory training will be able to be tracked. If the training is not completed consequences, such as not allowing the person to work in a position until the training is completed, can be implemented. She is concerned that a number of employees fail to attend required programs and feels that the apathy shown by some employees hurts the preventative aspects of the health and safety program. Another strong aspect of the training programs is that employees are paid during their attendance at the programs, whether it is a 1 hour or 8 hour program. The database is seen as a strong preventative component to the overall health and safety strategy.

Patrick Jung performs a number of functions in the organization as the Coordinator of Protective Services and Safety Coordinator. Since the receipt of the Improvement Orders he has been assigned to spend 10% of his time on developing effective responses to those improvement orders. In reality, a number of individuals indicate that he spends much more that 10% of his time on safety and health issues. Since the improvement orders have been received there have been strong efforts to address the issues identified in those orders. Manitoba Workplace Safety and Health has recognized the significant accomplishments in the safety and health areas at SOGH and have approached Patrick to use the hospital as an example for other institutions. Patrick sits as an ex officio member on the Workplace Safety and Health Committee (WSH Com). This committee reviews any health and safety issues that are unresolved by unit managers, develops health and safety policies and practices, identifies and takes preventative actions where hazards have been identified, and reviews the results of accident investigations. This committee is mandated by provincial legislation, is composed of both labour and management representatives, and includes 2 representatives from the Wellness Institute. In the early days after the improvement orders were received the WSH Com met biweekly but as the workload to bring the facility in compliance with the legislation has lessened, these meetings have been reduced to monthly meetings.

When incidents/accidents do occur they are investigated by a group of employees who are trained to serve as accident investigators. They are responsible for providing an unbiased report and view of the incident. The importance of the health and safety function is supported from the senior management. Evidence of this support is that reports on health and safety are included as a standing agenda item at management team meetings. The reports were originally provided by David but are now provided by Patrick.

Health and safety information is communicated broadly to employees. There is a bulletin board where minutes of the health and safety committee meetings are posted, new initiatives are explained, results of accident investigations summarized and remedial actions are described. Patrick also cites one of the greatest problems in the health and

safety area is the apathy by some of the employees, but he thinks that SOGH has been making great improvements in health and safety over the last couple of years.

Workers Compensation Experience at SOGH

The Occupational Health Branch of Workplace Safety and Health of Manitoba, provides summary information to organizations so that they can track their worker's compensation claims experience. The following table summarizes SOGH's workplace injuries and compensation claim experience for the period of 2000 through 2005:

Category	2000	2001	2002	2003	2004	2005
Days Lost	3313	3257	3733	3192	2509	2915
Total Injuries	77	84	75	66	70	75
Total Direct Costs ($)	205,725	272,807	283,240	246,494	173,712	283,315
Average days/claim	27.6	33.9	26.2	27.3	18.4	38.8
Total Loss claims	49	60	59	48	50	48

Source: Worker's Compensation Board of Manitoba, report to Seven Oaks General Hospital

The hospital management recognizes that the data suggests a downward trend in days lost and associated costs until 2004. In 2005 this trend moved upward once again. Janice thinks one of the reasons for the upward trend is the increased emphasis on employee safety and health. Employees are more aware of the policies, practices and procedures and recognize they should report any incidents, accidents and injuries. The upward trend may partially reflect more awareness and reporting from employees, not an increased incident rate. Yet worker's compensation costs remain a management concern.

The Relationship between the Wellness Institute and SOGH

In the early years of existence the WI primarily played an external role directed to community members. In 2001 due to the Board's recognition that the workforce was aging, and the need to keep employees health and well, a pilot Workplace Wellness program was launched. The program was designed to be a role model and test case that could be expanded to other groups within the hospital, and used as a prevention model offered to other organizations. The Workplace Wellness program was managed by a team of six employees and six managers. Health Risk Appraisals (HRAs) were administered to WI staff in the Spring, 2001. An outcome of the HRAs was the development of Personal Wellness Plans for interested employees. Included in the plans were health profiles, comparison profiles of employee fitness levels to benchmarks, and suggestions for making healthier lifestyle choices (Lamontagne, 2002).

Two more pilot projects were conducted in the Medicine and Materiel Services departments of SOGH. With these two pilot projects the WI began offering programs for hospital staff beyond individual WI memberships and visits to the institute initiated by staff members. The two departments were chosen because they were quite different from each other. The Wellness pilot programs were adapted from the *Well Source* model, developed in the U.S. The model as applied by the WI consisted of four steps:

1. Gathering of baseline information on employee health indicators (the Health Risk Appraisal (HRA), and fitness and health assessments) and development of a Wellness Team consisting of both employees and managers.
2. Development of the program's operation plan – a 12 month time frame, budget, events and an evaluation plan that focused on issues defined by the Wellness Teams, including teamwork, communication and culture. The plans were tailored to the specific identified needs of the two departments.
3. Implementation
4. Evaluation (second administration of the HRA, and assessment of other results) (Lamontagne, 2002)

These two pilot projects with the close working relationship between staff from the WI and the Wellness Teams developed a clearer connection between the WI and the promotion of staff wellness.

Another project that established a connection between SOGH and the WI was the Injured Workers Program (IWP). This program, begun in the early 1990s, was a work injury management program that was jointly conducted by the WI and the Workers Compensation Board and offered to the community. Due to it's success in the community the WI offered the program to the hospital. The program was designed to reduce employee injuries in the hospital, help speed recovery and shorten the time employees were away from work when injured. This program has been very successful and has reduced the frequency of certain types of injuries, the total time lost to these injuries, individual injury recovery times, the pain and suffering due to injuries and workers compensation premiums; and has led to increases in staff morale, productivity, and positive feelings about the workplace. This program continues to be managed jointly by the WI and the occupational health nurse, Janice.

While the Wellness pilot projects and extensions to those projects to other departments were effective, the WI staff perceive that they are generally seen as an independent arm with an external focus. The IWP has been an exception to the general tendency to keep the activities, expertise and experience of the WI staff distinct from the health and safety functions that fall under Human Resources. There have been notable exceptions, but even in these cases the WI provides services for the hospital.

Healthy Organization Strategy

In July, 2005, Carolyn, produced a document that outlined the new Healthy Organization (HO) Strategy that would serve as the future direction of the organizational development and internal hospital wellness strategies. A decision was taken to rename the "Organizational Development (OD) Committee" to the "Healthy Organization Committee" (HO Com). This committee is responsible for the coordination and accountability of the broad-based healthy organization strategy. The HO Com grew out of a number of issues related to the previous OD strategy. The OD strategy was considered too broad-based to focus on the health, safety and wellness issues within the hospital. Adoption of the Healthy HO strategy lead to an overall healthy organization vision and four goals. The vision is "To encourage optimal health for all SOGH employees while cultivating a positive healthy culture where employees choose to work, thus laying the foundation for exceptional productivity, extraordinary clinical excellence and outstanding patient satisfaction". The four goals were revised from the previous goals of the OD strategy:

1. To develop and nurture an organizational culture where employee health and wellbeing is valued, respected and cultivated.
2. To promote holistic well being by providing programs that increase personal responsibility for health and offer healthy intervention strategies that can improve the health and fitness of staff.
3. To provide a safe and healthy work environment.
4. To create a supportive and responsive culture that promotes the use of available work-life options and fosters a healthy balance between work, personal and community responsibilities.

The basic framework for the operation of the Healthy Organization strategy was developed by Carolyn and Lisa, reviewed and approved by the Executive Management team and is now ready for implementation. The progress to date includes the establishment of an HO Steering Committee to coordinate and be responsible for the overall implementation of the HO strategy. The committee membership is broad-based including: Carolyn Steiner (Chair and Chief Operating Officer), CEO (David Brown), Chief Human Resource Officer (Tristan Walker), Denise Boyd (Manager of Education Services), Barbara Havener (Speech Language Pathologist and Professional Lead), Casey Stewart (Professional Lead for Occupational Health), Jennie Ambrose (mid-Manager, Patient Care Team), Jack Reimer (Finance Manager), Lisa Habner (Director, Rehab Services), and Betsy Klosser (Program Director). The strategy was designed to be coordinated through work groups. Initially, four have been identified. A number of roles and responsibilities of the HO Steering Committee have been specified:

- Reviewing and recommending policies, standards and initiatives relating to major areas of organizational health and wellbeing. Ensuring that the strategy is integrated and compliments HR activities.

- Reviewing the short and long term plans for organizational health improvement, and other major improvement initiatives and recommending these plans to executive and the full board.
- Approving a set of key indicators for measuring organizational health and well-being, including employee satisfaction and utilization of programs and services, reviewing periodic reports on these indicators compared to organizational goals, long term trends and industry benchmarks; and reporting in a summary fashion to the executive and full board.
- Monitoring timely, summary reports of programs and improvement activities and taking appropriate action to insure that these activities meet standards and the organization's quality policies, standards and goals.
- Taking advantage of education opportunities to stay up-to-date on important trends in best workplaces.
- Reviewing and making recommendations to the executive and board on any other matters pertaining to the healthy organization process.

The design of the strategy calls for the four work groups to be established in the areas of disability management, health promotion/disease prevention, work life balance and culture. A leader will be assigned to each of the groups and be responsible for ensuring that the group's activities are accomplished. Each work group will be responsible for developing short (annual) and long term (3-5 year) plans; develop a key set of indicators to measure performance outcomes, satisfaction and utilization; monitor improvement activities and take appropriate action to insure that these activities meet standards and goals; and develop educational strategies to stay up-to-date on important trends in best workplaces. The work groups also serve as an integrating mechanism for the traditional HR managed health and safety functions and the functions carried out by the WI. The work groups and their areas of responsibility include:

1. Prevention and Treatment
    i. Injured Workers Program
    ii. Health and Safety Committee
    iii. Critical Incident Stress Management
    iv. Occupation health nurse
    v. Employee Assistance Program
    vi. On-site crisis support counseling
    vii. Grief ministry
    viii. Injury prevention training
    ix. Ergonomic Assessments
    x. Job Demands Analysis
    xi. Return to work programs

2. Health Promotion/Disease Prevention
   Workplace wellness program:
    i. Health Risk Appraisal
    ii. Risk factor reduction interventions
    iii. Health screenings

iv. On-site massage and reflexology
v. Health education classes
vi. Subsidized smoking cessation
vii. Healthy nutritious food services
viii. Staff rest/lounge areas
ix. WI membership discount(s)
x. Plan, coordinate & integrate workplace health & wellness services externally and internally

3. Work Life Balance
   i. Childcare solutions
   ii. Reduction of work time
   iii. Employee Assistance Program
   iv. Eldercare
   v. Special leave policies

4. Culture
   i. Mission, vision, values – hiring, orientation, on-going opportunities
   ii. Leadership development – initial and on-going
   iii. Performance management
   iv. Reward and recognition – align with values

The proposed structure of the revised Healthy Organizations strategy (implemented in January, 2006) resulted from a review of issues related to the problems in coordination of the health and safety and the wellness functions. The structure also exemplifies the need to encourage and formalize more integration of activities conducted by HR and WI. In the early experience of the HO strategy implementation (prior to 2006) a number of issues were identified, they include:

- Disjointed Actions: The OD and early HO strategies were characterized by actions, both similar and dissimilar, taken by various groups with overlapping responsibilities. More focus needs to be placed on multiple individuals coordinating their efforts and the development of both short and long-term focus to their activities. For example, ergonomics assessments were conducted by an outside consultant when the WI has ergonomics specialists on staff who could conduct these assessments at much lower cost.

- Lack of Accountability: The previous strategy did not have appropriate reporting and accountability in place for individuals operating in key positions to implement initiatives.

- Loss of energy and focus: A new strategy is needed that permeates all levels of SOGH and is highly visible to all who come in contact with the hospital.

- Disconnect with operations: The role that various clinical and non-clinical support functions play in promoting organizational health and employee health, safety and wellness was unclear. This lack of clarity led to a certain level of apathy which translated into a lack of participation in meetings and a noted lack of attendance.

- Lack of communication & coordinated planning: Different functional areas pursue initiatives, programs, and activities independently with little or no communication. In some cases this had led to redundant offerings by HR and the WI (see the ergonomics example above). A strong collective approach is needed to discuss and apply new best practice approaches to health, safety and wellness, use of collective exchanges of ideas, identify gaps in current versus desired policies and practices, take advantage of feedback from various sources, plan short and long-term strategies and collectively review/monitor and respond to outcomes and develop a continuous learning model.

- Conflict in models: At least two models are currently operating to manage health, safety and wellness of employees. One model relies on identifying discreet needs and tends to be more reactive in nature. For example, high levels of musculoskeletal injuries has led to training programs to address this issue, e.g., the STAR and IWP programs. A second model is more comprehensive and is more focused on a general preventative approach. Both models have strong proponents and positives and negatives are associated with each approach. The first focuses on identifiable hazards and addresses those concerns directly. The second is a broader based cultural approach that attempts to use a health, safety and wellness values based culture to encourage employees to examine all of their behaviours and attitudes. Upon self-examination and examination of others behaviours, employees might be more attuned to health risks and hazards and take a more proactive approach to reducing them.

Healthy Organization Strategy Implementation

Carolyn and Lisa have discussed the implementation of the HO strategy a number of times. Foremost in their approach is the consideration of how to integrate the health and safety and wellness approaches and activities; develop a more comprehensive strategy; and translate ideas that are on paper and approved into action. They have decided that the new HO steering committee (HO Com) should be organized to coordinate and be responsible for the change initiatives. Lisa is now faced with the responsibility of trying to implement the workplace wellness strategy through the HO Com. Now that the basic strategic direction has been identified she ponders a number of specific implementation questions:

1. How does she manage the process when she has no formal authority relationships with most of the members? (The new reporting relationship has made a

connection between her role in the WI and Workplace Health Services which falls under HR.)

2. What actions should be taken to form the work groups and encourage them to adopt the proposed responsibilities and initiate the needed actions?
3. How does she get buy-in from units such as HR which has traditionally been responsible for many of the health and safety functions?
4. Who are the proper people to leverage the changes needed and to serve as localized change leaders?
5. Are the members of the HO Steering Committee the right people? What are the needed skills, attributes and positions of those individuals?
6. What should be in an organization-wide communication plan to inform staff and gain their support for the needed changes?
7. How does one drive the plan throughout the organization?
8. How should effective change be recognized and rewarded?
9. How should the change be institutionalized, e.g., should the strategic change be integrated into succession planning?
10. How should resistance be minimized and managed?
11. What are the outcomes that should be measured and how will positive progress be determined?

Lisa knows that in order to move the integrated workplace HO strategy forward she needs some answers to these questions. At the meeting of the HO Com, that just took place, a presentation was made that identified the successes of the WI and SOGH, the needs for a more integrated strategy and the components that needed integration (see Exhibit F). From the discussions it was clear that there were various levels of commitment to moving forward. It was clear that the WI was still seen as a peripheral arm of SOGH and that there were a number of challenges that would need to be dealt with if the integrated HO strategy was to be effectively implemented.

References

Lamontagne, F. *Seven Oaks General Hospital.* (2002). A case study published by the Canadian Labour and Business Centre. May be found at www.clbc.ca.

Positively Healthy, Fall, 2005. A publication of Seven Oaks General Hospital and the Wellness Institute.

Positively Healthy, Winter, 2006. A publication of Seven Oaks General Hospital and the Wellness Institute.

Positively Healthy, Winter, 2005. A publication of Seven Oaks General Hospital and the Wellness Institute.

Exhibit A: Values, Mission and Vision of Seven Oaks General Hospital

Values

Our values stem from a community heritage of cooperative spirit, grounded in the belief that our shared humanity is sacred.

Integrity: We adhere to strong moral and ethical principles. We communicate openly and honestly. We demand the best of ourselves in all that we do.

Person Centred: We are committed to establishing personal connections, acknowledging the dignity of each individual. We encourage and value patients' and families' participation in their care.

Quality: We continually seek new ways to improve quality and outcomes. We strive for excellence and innovation.

Learning: We support and foster an environment of continuous learning through training, education, research and organizational development.

Wellness: We are committed to promoting the principles of illness prevention and healthy living in our community.

Team: We work together to achieve our common mission and goals. We understand the role and we value the contribution of each team member.

Spirituality: We acknowledge the central role of spirituality in facilitating mental, physical and emotional health.

Stewardship: We value and respect the environment and we manage our resources responsibly.

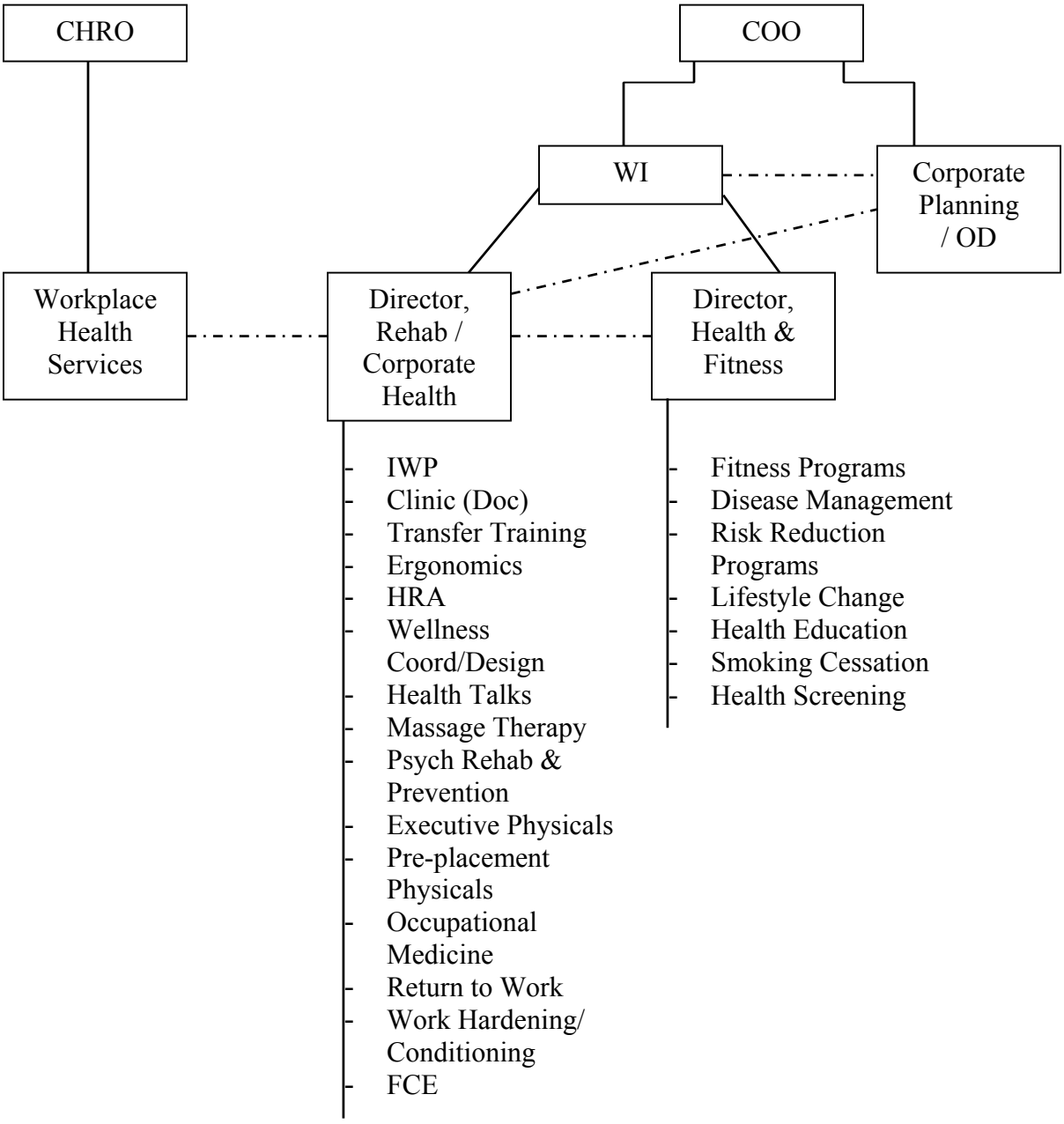
Mission

A healing community dedicated to providing holistic health and wellness services with skill and compassion.

Vision

To be recognized as a leader among community health centres for our approach to holistic care, healing and wellness.

Exhibit B: New Reporting Structure – IWP & Wellness Services (October, 2005)



SEVEN OAKS General Hospital

Exhibit C: Organization Structure (September, 2005)

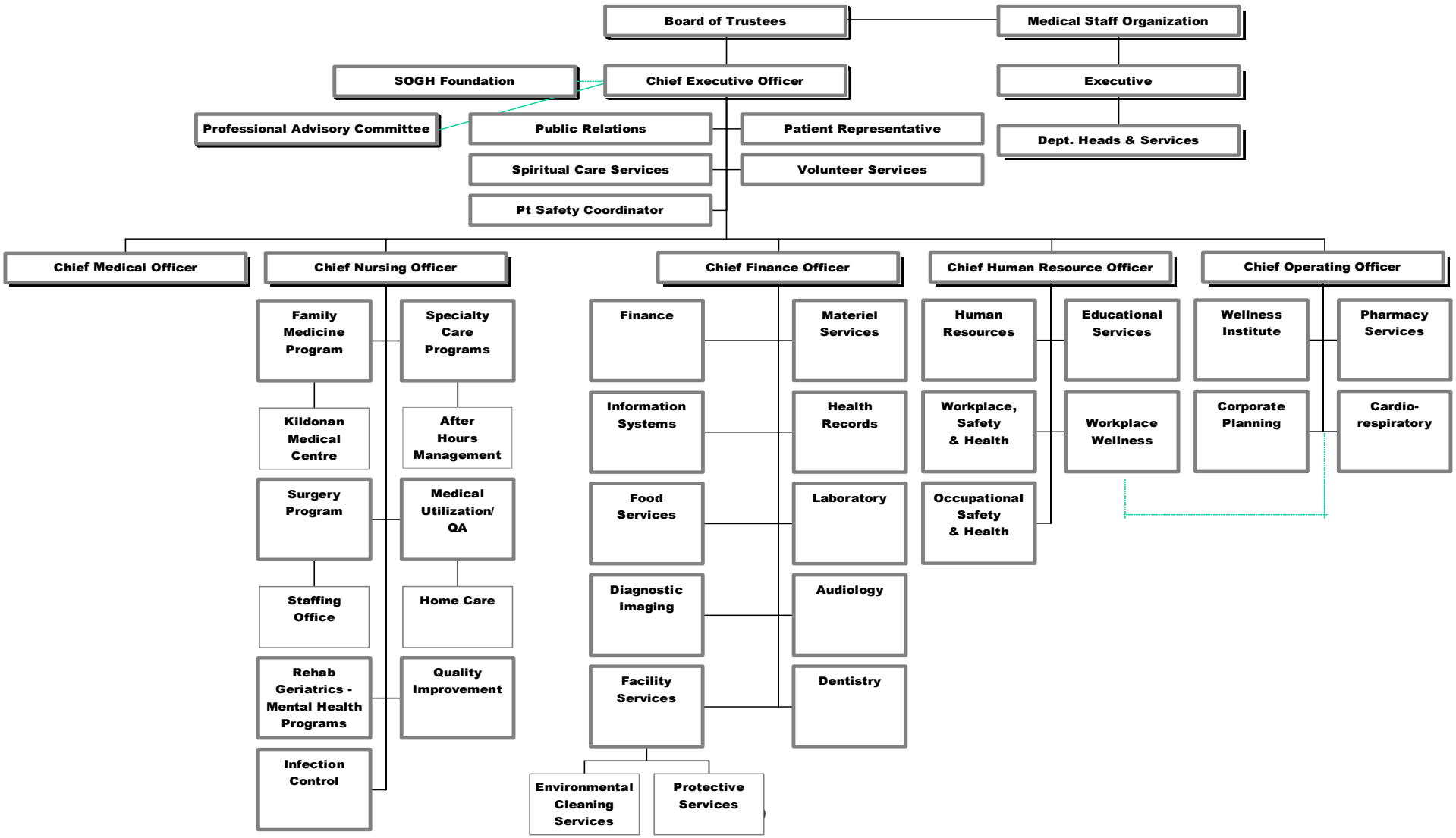


Exhibit D: Requirements of a Safety and Health Program

1. Policy Statement

   In consultation with the workplace safety and health committee, the employer shall document a policy statement demonstrating their commitment to safety and health of all workers in the workplace. The policy statement must be made available to all workers or other persons employed at the workplace, the safety and health committee, and a Safety and Health Officer upon request.

2. Hazard Control – Safe Work Procedures

   Upon identifying known and potential hazards in the "Job Hazard Assessment" (JHA), the employer, in consultation with the workplace safety and health committee, shall develop and implement safe work procedures with control measures effective to ensure the safety and health of workers.

   The documented safe work procedures shall include, but not limited to, the following:

   i. Identification of the task described.
   ii. Description of hazards associated with the process, equipment, or chemical.
   iii. Personal protective equipment required to safely perform the task.
   iv. Control measures associated with hazards and how they provide protection.
   v. Clear descriptions of the steps to follow to safely perform the task.

3. Emergencies – Identify Personnel & Resources

   In consultation with the safety and health committee, the employer shall develop emergency procedures identifying who is responsible for coordination, and the action taken in event of an emergency. The procedures must include, but not limited to:

   Situations that could produce emergencies,
   Accidents causing serious injuries,
   First aid, fire evacuation, and chemical spills.

   The procedures must be easily referenced, concise, and understandable. All workers must be trained on the content of the procedures and location of the resources.

4. Statement of Responsibility

   Statement of responsibility for employer, supervisor, workers and other persons.

The Owner, Employer, Managers, Supervisors, Workers, Safety and Health Committee, Prime Contractors, Contractors, Subcontractors, Self—employed and Suppliers are individually accountable under the WSH Act, for certain safety and health responsibilities in this workplace.

In consultation with the workplace safety and health committee, the employer shall cause and document, specific managers, supervisors and other persons as being accountable for implementing and maintaining each program element of the workplace safety and health program. The documented statement of responsibilities shall be communicated to workers.

5. Scheduled Inspections

Inspections are an effective tool for identifying and correcting hazards before they can cause an incident.

In consultation with the workplace safety and health committee, the employer shall establish a documented policy and methods for conducting regularly scheduled workplace inspections. The inspection methods shall include, but not be limited to; work practices and procedures, machinery, tools, equipment, hazardous material storage and handling, control measure use and effectiveness, personal protective equipment, and facility safety.

6. Chemical & Biological Hazard Control

The inspection revealed that the employer requires workers or other persons at this workplace to use, handle, store, dispose of, or be in close proximity to a variety of Controlled Products.

These Controlled Products may pose a health hazard. Based on the results of the inspection and discussions with the employer and worker contacts, it is the undersigned officer's opinion hazard information for the Controlled Products has not been evaluated in accordance with MR 53/88 (Workplace Health Hazard Regulation).

a) Evaluation of Controlled and Consumer Products

The employer, in consultation with the Workplace Safety and health Committee, shall evaluate each Controlled Product by referring to the pertinent Material Safety Data Sheet (MSDS), product label, or other information and conditions of use in the workplace to;

i. Determine if it may pose a health hazard to workers or other persons in your service, and
ii. Where a Controlled Product is, or contains a designated material as noted in MR 53/88 Schedule B, the evaluation shall be deemed to have

been done and to have disclosed that the designated material is a health hazard.

b) Prevention Plan

The employer shall, in consultation with the Workplace Safety and Health Committee, make or cause to be made, implement, and maintain a documented prevention plan in accordance with MR 53/88 section 33. The plan shall outline implementation time lines, with the steps that will be taken to prevent or eliminate health hazards to workers or other person from each Controlled Product in the workplace. The prevention plan shall be maintained in accordance with MR 53/88 34.

A prevention plan guidance form outline the requirements of a plan was provided to the employer's representative for compliance assistance.

7. Contracted Employer (s) or Self-Employed Person (s) at Your Workplace

In consultation with the workplace safety and health committee, the employer shall:

a. Establish criteria for evaluating and selecting employers and self-employed persons to be involved in work at the workplace, and
b. Develop and document procedures to regularly monitor employers and self-employed persons in the workplace.

8. Training Plan for Workers and Supervisors

A. Worker Training

When new workers, or currently employed workers at a workplace are introduced to new processes, equipment, tools, systems or chemicals, instruction and training must be provided. Worker instruction and training shall ensure workers are aware of the hazards associated with the process, equipment, or chemical they are working with, or could be exposed to, and the safe work procedures that must be followed to protext themselves or others from those hazards.

The employer, in consultation with the Workplace Safety and Health Committee, shall ensure all workers, and other persons receive instruction and training on all processes, equipment, and chemicals they will be exposed to. The new worker (s) orientation and currently employed workers instruction and training shall include, but not be limited to, the following:

i. Description and identification of the hazards associated with the process, equipment, tool, system or chemical.
ii. The control measures associated with the hazard, how they provide protection and the hazards for which they are intended. (Examples of control measures include personal protective equipment, guards & written procedures).
iii. How, when and why to use the control measure.
iv. The limitations of the control measure.
v. A review of all personal protective equipment to be used.
vi. A review of all written safe work procedures and policies related to the task.
vii. A review of all applicable emergencies measures, including first aid facilities, and evacuation procedures.

The employer shall determine and document how often worker competency is to be evaluated and what methods of evaluation will be used and how will workers be deemed as competent. The employer must ensure the worker is competent prior to being exposed to the workplace hazard associated with the process, equipment, tools, systems or chemical.

All worker evaluation related documentation used to establish competency shall be available for review by a Safety and health Officer upon request.

B. Supervisor Training

All supervisors, lead hands, and workers who are "temporary" supervisors require all of the training given to workers noted above, including their duties under section 4.1 of the WSH Act, and elements of the workplace safety and health program, respecting the role and responsibility of the supervisory position.

The employer shall ensure all supervisory instruction and training includes, but is not limited to the following"

i. WSH Act and Manitoba Regulations applicable to the supervisory position.
ii. Elements of the workplace safety and health program applicable to the supervisory position.
iii. Description and identification of the hazards associated with applicable processes, equipment, or chemicals that workers may be exposed to under their supervision.
iv. The control measures associated with the hazard, how they provide protection and the hazards for which they are intended. (Examples of control measures include personal protective equipment, guards, & written procedures).
v. How, when and why to use the control measure.

vi. The limitations of the control measure.
vii. Personal protective equipment to be used.
viii. All written safe work procedures and policies related to the task.
ix. All applicable emergencies measure, including first aid facilities, evacuation procedures.

9. Investigation Incidents, Dangerous, Occurrences and Work Refusals

A workplace accident or dangerous occurrence may result in a worker(s) or other persons, suffering injury or illness. Conducting an incident or dangerous occurrence investigation is a systematic method in identifying root causes, as a means to determine the corrective measures required preventing a reoccurrence.

In consultation with the workplace safety and health committee, the employer shall develop documented policies and procedures for (accident, dangerous occurrence and work refusal investigations) that include, but are not limited to the following:

A. Persons who will be conducting incident investigations
i. The time lines in which an investigation is to be conducted,
ii. The process that will be used to gather information, determine root causes, implement corrective measures and follow up,
iii. The investigators authority to lockout/tag out dangerous equipment
iv. Who will receive notification of incident,
v. Who maintains documents, reports and records.

B. Cause the safety and health committee, or representatives of the committee, to be trained and educated on the techniques of conducting an incident investigation. (The WSH Division offers a regularly scheduled course entitled “Investigating Workplace Accidents”)

C. Cause investigation report(s) be captured on a form acceptable to the Safety and Health Officer. The document titled “Workplace Safety and Health Committee Incident Investigation Summary Report” is deemed to be an acceptable format for the investigation report. A sample of this document can be found on the “Investigating Workplace Accidents” Interactive CD-ROM.

E. Cause all completed incident investigation reports to be forwarded to the Safety and Health Officers, upon request.

10. Worker Involvement

Concerns expressed by workers in the workplace must be responded to promptly, and workers kept informed on the status of any corrective action. The intent of a

workplace safety and health committee is to enhance the ability of workers and employer to resolve safety and health concerns in a reasonable and cooperative manner.

In consultation with the workplace safety and health committee, the employer shall:

A. The functions and duties of the Safety and Health Committee shall be in accordance with the Manitoba Regulation 106/88R and the accompanying code of practice.

B. Provide a designated safety and health bulletin board of suitable size to pose the following information;

i. The names of the committee members and expiry dates of their terms of office;
ii. The scheduled dates and agenda of each committee meeting;
iii. The minutes of the preceding meeting;
iv. Items issued from time to time by the Workplace Safety and Health Division and intended to be so posted;
v. Items recommended from time to time by individual committee members

C. Allow each member of the committee to take education leave for a period of two normal working days, without loss of pay or other benefits, for the purpose of attending workplace safety and health related seminars, programs, or courses of instruction. Newly elected committee members shall receive training on the Workplace Safety and health Act legislation.

11. Safety and Health Program Evaluation and Revision

This Officer identified the absence of a procedure to evaluate and revise the workplace safety and health program within a three-year time period. Full or partial reviews and revisions are required when circumstances at your workplace change that may affect the safety and health workers.

SECTION 35 OF THE ACT REQUIRES YOU TO PROVIDE A WRITTEN COMPLIANCE REPORT TO THE UNDERSIGNED SAFETY AND HEALTH OFFICER AND A COPY TO THE SAFETY AND HEALTH COMMITTEE/REPRESENTATIVE WITHIN SEVEN DAYS AFTER THE EXPIRY OF THE PERIOD SPECIFIED IN THE ORDER. IF THERE IS NO SAFETY AND HEALTH COMMITTEE/REPRESENTATIVE A COPY MUST BE POSTED IN THE WORKPLACE.

WHEN A PERSON FAILS TO COMPLY WITH AN IMPROVEMENT ORDER AN ADMINISTRATIVE PENALTY MAY BE ISSUED PURSUANT TO SECTION 53.1 OF THE ACT.

Exhibit E. Second Improvement Order - 19 orders and Areas of needed Improvement

- Ergonomics – a number of areas were cited where musculoskeletal risk factors were not adequately addressed
- WHMIS-MSDS (Workplace Hazards Management Information System – Material Safety Data Sheets)
- WHMIS – Inventory – Controlled products need to be inventoried and MSDS need to be placed in close proximity to the controlled products.
- WHMIS – Education – A training program existed but evaluation systems were not in place to ensure specific competencies were acquired by appropriate workers
- WHMIS – written summary – summaries of worker education and training programs was needed
- Guarding – machinery was identified that needed appropriate guarding
- Electrical – panel access – electrical panels were not readily accessible to persons in the event of emergency and/or operational tasks
- Electrical hazards – a number of electrical hazards were identified
- Electrical – de-energize – lock out policy procedure training – appropriate procedures were needed to ensure electrical maintenance was safe
- Electrical – work on energized – conditions were specified where workers would work on energized electrical equipment
- Steel storage racks – areas were identified where racks were not properly installed or maintained
- Fall protection policy, procedure, equipment and training – a policy was needed to deal with falls that could occur from persons working at heights greater than 2.5 metres
- Working in confined spaces – a policy and procedures were needed to deal with employees who were working in confined spaces
- Working alone – need for a plan to ensure the safety, health and welfare of workers who were working alone when ready access to assistance was not available
- Powered lift truck – certificate – need for certification of powered lift truck operators
- Personal Protective Equipment – Eye & Face – Hand – Risk Assessment – Policy – Procedure- Training – need for policy and procedures to deal with individuals with eye, face and hand risks
- Safety and Health Committee/Representative – Educational leave – need to provide the required 2 days of paid education leave per year to attend safety and health training, programs, seminars, or courses of instruction
- Hearing conservation and noise control – need to implement a hearing conservation program consistent with provincial regulations
- Emergency eye wash stations – need for identification of areas where emergency eye wash stations were needed and proper policies and procedures adopted to ensure the effective use of those stations.

Exhibit F. Linking the Strategies