Agence de la santé et des services sociaux de Montréal

Guide to Promoting Healthy Workplaces in Healthcare Institutions

Winning Strategies for Health Gain

A work of the International Network of Health Promoting Hospitals and Health Services in collaboration with the Montreal Network of Health Promoting Hospitals and CSSSs

Creating healthy settings

Québec

The *Guide to Promoting Healthy Workplaces in Healthcare Institutions* is a publication of the Montreal Health and Social Services Agency. This Guide arises out of the work of the International HPH Health Promotion for Staff/Healthy Workplace Working Group in collaboration with the Montreal Network of Health Promoting Hospitals and CSSSs. It constitutes a reference tool designed to support healthcare institutions in their efforts to plan for and implement Standard 4 of the International Network of Health Promoting Hospitals and Health Services, initiated by the World Health Organization (WHO).

Standard 4 – Promoting a healthy workplace: The management establishes conditions for the development of the hospital as a healthy workplace.

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Note: In this document, masculine pronouns are used in their generic sense and therefore refer to both women and men.

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Our heartfelt thanks also go out to all the healthcare institutions that agreed to share their inspiring projects with us.

Glossary

ASSSM	Agence de la santé et des services sociaux de Montréal [Montreal Health and Social Services Agency]
BMI	Body Mass Index
BNQ	Bureau de normalisation du Québec [Quebec Standards Bureau]
CHSLD	Centre d'hébergement et de soins de longue durée [Long-term Care Centre]
CLSC	Centre local de services communautaires [Local Community Service Centre]
CRDITED	Centre de réadaptation en déficience intellectuelle et troubles envahissants du développement [Rehabilitation Centre for people with intellectual disabilities and pervasive development disorders]
CSSS	Centre de santé et de services sociaux [Health and Social Services Centre]
DEHP	Di(2-ethylhexyl) phtalate
EAP	Employee Assistance Program
EPA	Environmental Protection Agency (United States)
FSC	Forest Stewardship Council
GHS	Globally Harmonized System
HPH	Health Promoting Hospitals and Health Services
HR	Human Resources
LEED	Leadership in Energy and Environmental Design
MSD	Musculoskeletal Disorders
MSSS	Ministère de la Santé et des Services sociaux [Ministry of Health and Social Services]
OHS	Occupational Health and Safety
PVC	Polyvinyl Chloride
SPHM	Safe Patient Handling and Movement
UHC	University Hospital Centre
UN	United Nations
WHO	World Health Organization

Preface

It is with great pleasure and pride that we are introducing this Guide, which was produced in collaboration with the International Network of Health Promoting Hospitals and Health Services, and which is the fruit of a massive effort, particularly on the part of the Montreal Network of Health Promoting Hospitals and CSSSs. We take this opportunity to extend our heartfelt thanks to all of the people and organizations that have made the creation of this Guide possible.

The purpose of this Guide is to implement and integrate **Standard 4: Promoting a Healthy Workplace,** initiated by the International Network of Health Promoting Hospitals and Health Services, a network founded by the World Health Organization (WHO).

In a health network comprising close to 60 million healthcare providers worldwide[a], managers of healthcare institutions often have to confront serious and sometimes conflicting demands, such as changes and increases in population health needs on the one hand, and a human resource reality on the other that, to varying degrees and depending on the context, manifests in an aging workforce, staff shortages in certain job categories, and significant employee turnover. Moreover, we must all contend with the fact of global austerity, no matter the country in which we live and work. These converging factors limit the resources available to us and constantly push us toward greater efficiency and innovation in order to maintain excellence in the standard of care that we must provide to our fellow citizens.

Despite this, expert consensus and an ever-increasing volume of scientific research both conclude that, regardless of the country or type of health system under study, when workplace health promotion programs are implemented using a comprehensive, integrated, multistrategy and participatory approach, such programs will, without fail, result in positive gains on many fronts: human resources management (improved job satisfaction, increased employee recruitment, reduced absenteeism, and reduced employee turnover); quality of care (reduction in nosocomial infections and adverse workplace incidents); and even financial (improved productivity, less need to rely on employment agencies). Such conclusions are driving change.

This Guide, which discusses workplace health promotion in concrete terms, constitutes an innovative, essential and practical tool to support managers of healthcare institutions in their many roles with respect to both their clientele and their employees. We hope the Guide will enable managers to offer their employees a more constructive work environment and the best possible conditions under which to carry out their work.

Enjoy your read!

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Montreal Network of Health Promoting Hospitals and CSSSs
A Network Initiated by the WHO

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a World Health Organization (WHO). (2006). *The World Health Report 2006: Working together for health*, 209 p.

Introduction

"Human performance is higher when people are physically and emotionally able to work and have the desire to work."

– O'Donnell, 2001[a]

Given their mission, it goes without saying that healthcare institutions are mainly concerned with the health of their users. But that concern also extends the health of their staff, who are devoted to the delivery of the highest quality of care and services to patients.

In order to provide their employees with a work environment that is conducive to achieving this goal, healthcare institutions have every incentive to adopt a healthy workplace promotion program, positive outcomes of which have been documented both scientifically and through expert consensus (improvement in the quality of care, improved employee attraction and retention, reduced absenteeism, increased productivity, financial gains, and many others). However, certain conditions must be present in order for staff to embrace these programs and for the benefits to become tangible.

In fact, the promotion of a healthy workplace should not be limited to activities centred on the individual. It should also address the working conditions that influence employee health and well-being. Therefore, apart from the range of health issues covered in a healthy workplace promotion program (e.g. psychological health and well-being, health and safety, healthy lifestyles)—about which we provide a detailed discussion in this Guide—such programs must also be designed using an integrated, multi-strategy process that targets both individuals and working conditions simultaneously, as well as encouraging the participation and investment of all employees. Such is the approach we advocate in this Guide.

Founded upon the examples of numerous projects implemented by healthcare institutions all over the world, and proposing a vast range of achievable activities as well as many recommendations and practical tips that are adaptable to your specific setting, this Guide will become a tool to help you through every step of this endeavour.

For more detailed information on the above, please refer to Part 1, *Introduction to the Guide.*

a Cited in: Lowe, G. (2003). *Healthy Workplaces and Productivity: A Discussion Paper,* Prepared for the Economic Analysis and Evaluation Division, Health Canada, April 2003, 52 p.

Introduction to the Guide

Introduction to the Guide

Why a guide to promoting healthy workplaces?

The *Guide to Promoting Healthy Workplaces in Healthcare Institutions*, founded on expert consensus in the field of health promotion, was specifically created to support the integration of one of the five standards that define good health promotion in hospitals, **Standard 4: Promoting a healthy workplace**. Standard 4 stipulates that "The management establishes conditions for the development of the hospital as a healthy workplace." Please refer to Appendix 1: *The HPH Network* for further details.

An aging population, a growing patient clientele, and increasing healthcare needs, coupled with staff shortages in certain professions, difficulties attracting and recruiting employees, retirements, managing maternity and sick leaves, overtime hours, work overload, stress, and many other issues, are a daily preoccupation for the vast majority of managers of healthcare institutions.

Furthermore, budgetary constraints – a reality in most countries – impose an added restriction to managers' room to manœuvre.

In order to respond to these challenges, the Health and Social Services Agency of Montreal (Quebec, Canada), in close collaboration with the International Network of Health Promoting Hospitals and Health Services (HPH Network) Working Group on Health Promotion for Staff/Healthy Workplaces, has produced a Guide that constitutes an indispensible resource for creating a healthy workplace. By proposing numerous innovative solutions, this Guide effectively becomes a key to attracting and retaining healthcare personnel. It is **an implementation and reference tool** based on expert consensus that provides managers and those in charge of health promotion with a fresh perspective and ample information to help them implement an integrated healthy workplace promotion program.

What scientific research and expert consensus are telling us

A wealth of recent studies in the healthcare field have demonstrated the positive effects of workplace health promotion programs, not only for employees[1, 2, 3, 4, 5, 6] (reduced absenteeism and employee turnover, improved employee productivity, and increased attraction and retention of personnel), but also for the quality of care provided to patients as well as patient safety[7, 8]. Moreover, studies of these programs have also shown financial advantages for healthcare institutions, specifically with respect to employee health benefit payments and health insurance costs[4, 5].

A few salient facts[8]:

- Taking part in a program promoting a healthy workplace is associated with a reduction in employee absenteeism;
- Taking part in a program promoting a healthy workplace is directly related to an increase in productivity;
- A link has been found between increased stress levels of staff and a corresponding increase in the risk of adverse events;
- Nursing staffing levels[a] are inversely proportional to patient mortality and length of hospital stay.

Additional important findings are presented in Appendix 2.

"So how much evidence do we need?" – O'Donnell, 2005[9]

The Guide: a practical and user-friendly handbook

This Guide is an easy-to-use tool that describes the major components of a healthy workplace promotion program. A number of projects carried out in healthcare institutions have been included to facilitate the assimilation of information on a multitude of relevant topics and provide the reader with a range of concrete examples.

The content of this Guide is based on the review of over 200 bibliographical references and more than 40 projects carried out by healthcare institutions, many of which were previously unpublished.

a Nursing staffing level refers to the ratio of nursing resources to the needs in terms of patient safety and quality of patient care. (Canadian Nurses Association, 2005).

While the Guide is comprehensive, it is not an exhaustive work, given the scope of the topics addressed. As in any written work, the editorial team made a number of decisions to maintain the coherence, clarity and user friendliness of this Guide.

The Guide is divided into four main parts:

> **Part 1** Introduction to the Guide
> **Part 2** Implementation Process and Certification
> **Part 3** Themes
> **Part 4** Project Descriptions

Part 2 – Implementation Process and Certification – contains two chapters:

> **Chapter 1. A Process for Implementing Healthy Workplaces:** This chapter details the planning process and serves as a framework to truly steer managers through each step of their action plan as well as guide them throughout the process of developing a healthy workplace promotion program. In keeping with the rest of the Guide, the implementation approach is decidedly action-oriented and focused on the practical features of each step. The implementation process must be put in a context specific to each component of a healthy workplace in order to ensure that the action plan is relevant to the particular issues surrounding each topic.

> **Chapter 2. Certification and Accreditation… a Framework for Action:** This chapter seeks to clarify a number of issues related to certification and accreditation and provide senior managers with the tools they need to determine whether to involve their institution in a certification process. It is worth noting that the process involved in seeking certain certifications can effectively take the place of the planning process described in Chapter 1.

Part 3 – Themes – presents detailed information on the main areas that should be targeted by a workplace health promotion program. Each themed chapter presents pertinent background information and provides definitions, practical tips, recommendations and examples of projects carried out within and across a variety of healthcare systems. The information on each topic helps contextualize the implementation process presented in Part 2, whether by defining the needs assessment indicators, exploring activity options or any other step in program implementation.

> **Chapter 1.** Supporting Employee Well-Being and Productive Management Practices;
> **Chapter 2.** Improving Employees' Physical Environment and Making it Safer;
> **Chapter 3.** Promoting a Healthy Lifestyle in the Workplace;
> **Chapter 4.** Taking Action to Reduce Workplace Social Inequalities in Health in the Workplace (considering the specific health needs of particular employee groups);
> **Chapter 5.** Integrating Sustainable Development: Making Choices that Protect the Environment

Part 4 – Project Descriptions

– a compilation of the detailed descriptions of each project.

Who should read the Guide?

This Guide is mainly geared toward **managers** of healthcare institutions **at any authority level**.

It was designed to enlighten senior managers with respect to their strategic orientations, but it also targets managers who are responsible for developing and coordinating part of or en entire healthy workplace promotion program. It is equally useful for any employee who is interested in the topic of workplace health promotion or who would like to propose some activities for his or her team or department.

What is the main purpose of the Guide?

The main goal of the Guide is to make it easier for managers to develop a successful workplace health promotion program. Such an outcome is possible when the implementation approach used is participatory and the proposed program is multi-strategic and consistent with the institution's other orientations. The implementation of such a program must also take into account the specific health needs of certain groups of employees.

Project descriptions

To illustrate the various themes covered in the Guide and offer some concrete examples of how they can be applied, Part IV presents descriptions of projects that have been carried out in a wide range of healthcare settings in countries all over the world.

Inventoried projects

These project descriptions were gathered from a massive inventory initiative led by the Montreal Health and Social Services Agency, which, in 2009, called out to member institutions within the regional and international HPH networks to submit their achievements in the area of healthy workplace development. Each project was evaluated by two independent reviewers, using the same criteria grid.

The criteria were as follows: **1.** Project objectives and structure; **2.** Organizational commitment; **3.** Project implementation and resources; **4.** Continuity of the project; **5.** Project evaluation, monitoring and outcomes; and **6.** Originality and innovation.

For each criterion, points were awarded and tallied according to the extent to which the project met sub-criteria. The reviewers also had the opportunity to provide comments and recommendations on each project.

Regional and international HPH committees then proceeded to evaluate each project. Only those projects considered most relevant were retained at the end of this evaluation process, and these are presented in this Guide.

However, we would like to remind the reader that all the projects that were submitted in 2009 have no doubt evolved since that time. Moreover, we are well aware of the enthusiasm the healthcare field has for this area, and of the vast number of important, high-quality projects currently under way that do not appear in this Guide.

Projects from institutions outside the HPH Network

Other projects were also retained for the purpose of illustrating the themes discussed in this Guide. These projects have been recognized in the health field for their quality through awards, at conference presentations, and through evaluation by an expert in the field.

How to use the Guide

At the beginning of each chapter, a list of key points is provided that summarizes the chapter's take-home messages.

Within the chapter, project summaries are presented in text boxes to demonstrate the various points made therein. Each project corresponds to a numbered descriptive sheet that can be found in Part 4 – Project Descriptions.

"Inspiring initiatives" are also presented in special text boxes within each chapter. These are not integrated projects, but rather practical activities that tangibly demonstrate a specific part of the chapter. Detailed descriptions of these activities are not provided.

"Suggested Readings and websites" as well as "Practical Tools" can be found either within the chapter, at the end of paragraphs that reference them, or at the end of the chapter if their content pertains to the chapter as a whole.

A list of references concludes each chapter.

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Appendix 1 – **The HPH Network**[b]

The International Network of Health Promoting Hospitals and Health Services

In 1988, the World Health Organization (WHO) undertook an international initiative with a view to supporting hospitals and their actions to promote health: The Health Promoting Hospitals (HPH) movement. This project, in keeping with the Ottawa Charter for Health Promotion (WHO, 1986), aimed to improve the health of patients and staff and promote the development of healthy settings as well as collaborative ties with the community. It targets a broader view of health than that of preventing illness. Specifically, it gives healthcare institutions the opportunity to actively contribute to public health objectives, which, given the growing prevalence of chronic illnesses, are becoming extremely important for improving the health of the world's populations. This movement's mission is to raise awareness about the concept of health promotion, contribute to its propagation in hospitals and health services centres and support its implementation on a national and international scale. This network comprises some 800 healthcare centres in several countries.

The International Network of Health Promoting Hospitals and Health Services:

www.hphnet.org

The Montreal Network of Health Promoting Hospitals and CSSSs (Montreal, Quebec, Canada)

The Montreal Network of Health Promoting Hospitals and CSSSs was founded in 2005 with the goal of reinforcing the capacity of its member institutions in the area of prevention and health promotion. The Montreal Network is a member of the International Network of Health Promoting Hospitals and Health Services and is coordinated by the Montreal Health and Social Services Agency (ASSSM). The role of the Montreal Network is to support its members in implementing the five HPH standards (see below), provide technical assistance and strategic advice, and foster discussion among member institutions by organizing regional meetings and conferences.

The Montreal Network of Health Promoting Hospitals and CSSSs:

www.hps.santemontreal.qc.ca

The Five Standards of HPH (Groene, 2006)

Standard 1: Management Policy

The organization has a written policy for health promotion. The policy is implemented as part of the overall quality improvement system, aiming at improving health outcomes. This policy is aimed at patients, relatives and staff.

The following publication was produced on Standard 1: Agence de la santé et des services sociaux de Montréal. (2010). *Guide to Develop a Health Promotion Policy and Compendium of Policies*, Montreal Network of Health Promoting Hospitals and CSSSs.

Standard 2: Patient Assessment

The organization ensures that health professionals, in partnership with patients, systematically assess needs for health promotion activities.

b Agence de la santé et des services sociaux de Montréal. (2010). *Guide for Integrating Health Promotion into Clinical Practice—With the example of the smoking cessation support program in hospitals*, Montreal Network of Health Promoting Hospitals and CSSSs.

Standard 3: Patient Information and Intervention

The organization provides patients with information on significant factors concerning their disease or health condition, and health promotion interventions are established in all patient pathways.

The following publication was produced on Standards 2 and 3: Agence de la santé et des services sociaux de Montréal. (2010). *Guide for Integrating Health Promotion into Clinical Practice—With the Example of the Smoking Cessation Support Program in Hospitals*, Montreal Network of Health Promoting Hospitals and CSSSs.

Standard 4: Promoting a Healthy Workplace

The management establishes conditions for the development of the hospital as a healthy workplace.

Standard 5: Continuity and Cooperation

The organization has a planned approach to collaborating with other health service levels and other institutions and sectors on an ongoing basis.

Appendix 2 – **Salient Findings from Research into the Promotion of Healthy Workplaces**

The following are findings cited in the 2010 Canadian Health Accreditation Report[c].

- A consistent relationship has been identified between low staff satisfaction and burnout, and adverse health outcomes (Aiken et al., 2002; Rafferty et al., 2007).
- Work life features such as teamwork, multidisciplinary approach, staff training, skills mix and team stability all affect rates of:
  - Nosocomial infections (Griffiths, Renz, Hughes and Rafferty, 2009);
  - Falls (Sovie and Jawad, 2001; Whitman et al., 2002);
  - Medication errors (Sovie and Jawad, 2001; Whitman et al., 2002).
- High staff turnover and vacancies were associated with poorer infection control outcomes (Griffiths et al., 2009).
- An inverse relationship exists between nurse fatigue and patient safety (Canadian Nurses Association and Registered Nurses' Association of Ontario, 2010).

c Accreditation Canada. (2010). *2010 Canadian Health Accreditation Report – Through the Lens of Qmentum – Exploring the Connection between Patient Safety and Quality of Worklife*, Ottawa, Ontario.

2 Implementation Process and Certification

Chapter 1

A PROCESS FOR IMPLEMENTING HEALTHY WORKPLACES

Key Points – Synthesis

1. Is this the right time to begin implementation?

> Be aware of the internal and external contexts.

2. An integrated, multi-strategy program implementation

> The health promotion program must combine:
  - Activities aimed at creating positive work environments;
  - Activities to raise awareness;
  - Activities centred on the acquisition of skills.

> Each project must not be designed as a series of independent activities on the same theme, but rather as a set of cohesive and organized activities that are part of an overall goal.

3. Initiating the change

> Organizational component: optimize the factors that promote successful change;

> Individual component: design the program implementation based on an informed perspective of the target group, in order to offer activities that are adapted to its stage of change.

4. Getting the program started

STEP 1: As a director or manager of a healthcare organization, begin by examining and reflecting on the situation.

> Employ simple but effective methods.

STEP 2: Establish a working committee and encourage employee involvement and participation in the process.

> The process must be participatory; in other words, it must engage a variety of employee groups throughout the program implementation and foster discussions between employees and managers.

STEP 3: Assess and analyze employee and workplace needs.

> Must be done in collaboration with employees.

STEP 4: Develop an action plan that corresponds to the identified needs.

> The activities must address the needs as well as the stage of change of the target group.

STEP 5: Communicate the action plan and promote activities.

> The chosen communication mode must be adapted to the group to which the activity is geared.

STEP 6: Evaluate the results and adapt activities.

> Communicate the results of the evaluation as well as any modifications that will be made to the program.

Introduction

1

The goal of this chapter is to propose a general process to guide managers through each step in the implementation of a healthy workplace initiative. It is a simplified proposal that allows managers great flexibility while ensuring key project management elements.

Factors to bear in mind

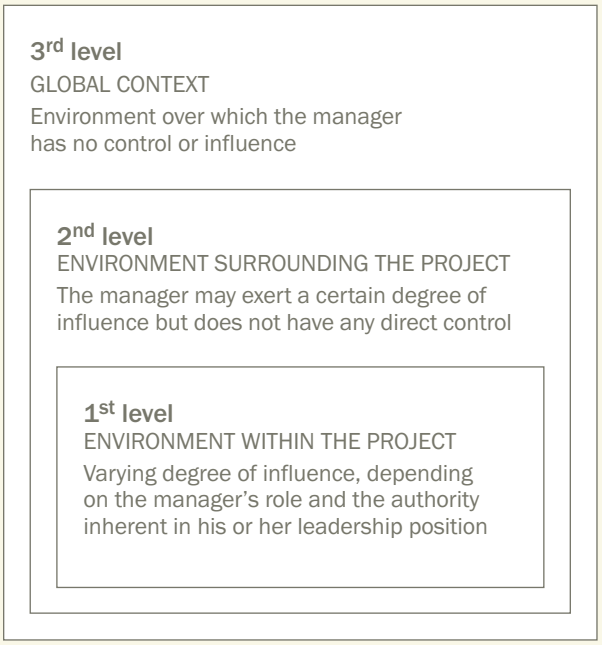
> This process must be adapted to the specific theme in question, aided by a simultaneous reading of the corresponding section;
> At each stage of the implementation process, it is important to remain aware of the diversity of populations working in healthcare and social service organizations and adjust your actions accordingly.

Is this the right time to begin implementation?

2

Before initiating any plans, it is imperative to ensure that the project aligns with the organizational context. Indeed, few things can be more frustrating than communicating plans, raising expectations, and using up precious time, only to realize that the actions that had been planned cannot be carried out due to conflicts with the existing context of the organization and/or its resistance to change.

The organizational context or environment can be divided into three levels, described according to the manager's ability to control or influence the various factors that may impact the project[1].



2

Before implementing a workplace health promotion initiative, it is crucial to have a thorough understanding of the current organizational context. For example, if major restructuring projects are planned (e.g. a merger, a unit relocation, reorganization of work within a particular staff category, etc.), it may be advisable to delay the start of the project work in order to ensure optimal employee participation and investment. However, in the case of a newly constituted team, such a project could serve as a catalyst for building team spirit. Similarly, it can be beneficial to begin work at a time of crisis within a division, so as to channel people's energy into a new project.

Factors to take into account:

> Global context: Any health system reforms, changes affecting the practice of certain professions, enactment of new laws, etc. that are under way or are expected in the near future;
> Organizational context: Any major organizational changes that are under way or being planned for the near future (e.g. merger of departments or healthcare centres, closure/opening/moving of a department, work restructuring of an employee category);
> Availability of employees: being understaffed, periodic work overloads (as a function of time of year);
> Context specific to the targeted department or employee category: significant turmoil within the department, high employee turnover, power struggles, etc.;
> New department head or manager in charge;
> Any other factor that could affect the project.

It is important to clearly understand the environment directly impacted by the project, the environment surrounding the project, and the global context.

3

An integrated, multi-strategy approach

Although awareness-building and information activities are good starting points for an action plan, they are not in and of themselves sufficient to change people's behaviours or create a healthy workplace. In general, the health promotion programs that have been considered exemplary have employed a multi-strategy approach that combines the following[2]:

> Activities that aim to create a **positive work environment**, thereby reflecting a commitment to workplace health on the part of senior management;
> **Awareness-building** activities that provide employees with the information they need to make informed decisions;
> Activities centred on the **acquisition of skills**, which inspire people to take a proactive role in changing their habits.

As such, each project must not be designed as a series of independent actions under a single theme, but rather as a well-organized set of actions that all operate cohesively toward a common goal: to provide the physical, cultural, psychosocial and job design conditions that maximize the health and well-being of healthcare providers, the quality of patient or user outcomes, and organizational performance[3].

In order to achieve tangible results, it is therefore critical to adopt an approach to workplace health promotion that employs multiple strategies, which are themselves incorporated into an integrated program. In other words, the various projects must align together as integral parts of a global action plan that touches the various aspects of the organization. Each component of the program or initiative must also reflect this multi-strategy approach.

Note: *In this chapter, the term "activity" is to be interpreted in its broadest sense. It refers to any action or intervention that is included in the action plan to meet the established goals (e.g. training, meetings, notices, workshops, monthly themes, reorganization of workspaces, or other types of modifications) for whatever theme is being addressed (physical environment, lifestyles, psychological health, social inequalities, etc.). For instance, an activity can consist of the installation of lamp posts in the parking lot so that night shift workers can reach their vehicles safely. Another activity might involve the organization of a walking group that does a 20-minute circuit twice a week at lunch hour, or the holding of a workshop on cultural diversity.*

Factors to consider:

> Each project must be designed as an integral component of the global action plan. Consider the relevance of the project to the overall plan;

> The actions of a given project must be varied in approach and employ different mechanisms: targeting individuals (training, notices), modifications to the environment (room design/layout, lighting), new services (more balanced cafeteria menus, on-site fitness classes), reorganization of work (flexible hours, mentorship program for new employees), etc.;

> Each action must be designed with a global view in mind, taking into account how the project correlates with the other themes, e.g. ensuring that evening and night shift workers have an opportunity to participate in the activity (social inequalities theme).

Ensure projects are in line with the overall global action plan and that a multi-strategy approach is always applied.

Project scope and flexibility

> With regard to the target population:
- Projects may be institution-wide or designed for a particular team or selection of departments.

> With regard to time:
- The project may be small or very specific in scale at the outset, and then be expanded as it gains in success;
- The scope of projects may also be readjusted as needed.

To motivate employee involvement, it may be worthwhile in certain cases to plan some activities in the very short term, so that staff can see some concrete examples of how the action plan can benefit them.

4 Initiating the change

To maximize your program's chances of success, we propose that two sets of conditions be applied throughout the change process. The first deals with the organizational aspects of implementation; in other words, all of the practical steps in a change process. The second relates to the steps involved in changing individuals' behaviour, which will be particularly useful when it comes time to define goals and activities for a target group.

Organizational component: factors promoting successful change[4]

The model presented below is an adaptation of Hunt's theoretical model (1992)[5], which blends a number of elements proposed by other authors on the same subject, including, in particular, those of Kotter (1996)[6].

Pressure to change: The presence of environmental constraints that push the organization toward the change. These are used by the administration to justify the change to their members and instill a sense of urgency to take action. This success factor implies the presence of at least one person whose dynamic personality has the power to motivate and inspire others to take action and effect the change.

Leadership and vision: The senior management's ability to effectively define the goals for the organizational change and communicate these goals to its members through an inspiring vision.

Capable people: The presence of a significant proportion of individuals within the organization who are capable of managing a transition effectively and seeing the initial interventions through to completion. This entails the adoption of a culture of openness to change, the development of the skill sets necessary to successfully carry out the change, and the mobilization of personnel to modify their behaviours toward the desired end result.

Initial concrete steps: High quality execution of a change process. This involves developing a simple and achievable action plan, having the people affected by the change participate in its planning, allocating the necessary resources to put the plan into action, identifying the existing forces that could propel or impede change implementation, and putting mechanisms in place to structure and monitor the change.

Concrete rewards: The existence of tangible rewards, as the change progresses, for the people who invest time and effort to generate the desired outcome. An improvement in the organizational situation (compared to the initial state) or in the individual's performance are examples of rewards, as is overt recognition of employees.

4

Individual component: the stages of behavioural change and strategies[7]

It is important to remember that even in a situation where the most robust organizational conditions are in place, the ultimate participation in workplace health promotion programs comes down to individual choice. In addition to advocating for a multi-strategy approach to interventions, it is also crucial to have an appreciation of the factors that motivate or hinder a person's decision to change. It is important to reflect on an individual's stage of change and offer programs that are appropriate to that stage.

Many social science theories have been developed to explain behavioural change. There is an extensive body of literature dedicated to understanding the intricacies of these models, some of which have been the subject of criticism[8]. The eight conditions[7] presented in this chapter (see Table 1) essentially represent the main theories of behaviour change.[a] One or more of these conditions must be present for a person to adopt a given behaviour. **The first three conditions are considered "necessary and sufficient" for adopting a given behaviour, and the remaining five affect the intensity and direction of the intention**[7]. Strategies aimed at helping meet each condition are also presented.

Table 1 – Conditions for Behaviour Change and Strategies to Help Individuals Meet Each Condition[7]

Note: Conditions 1, 2 and 3 are judged to be necessary and sufficient for adopting a given behaviour.
Conditions 4 to 8 affect the intensity and direction of the intention

CONDITION 1	**THE PERSON HAS THE FIRM INTENTION OF ADOPTING THE BEHAVIOUR (OR HAS MADE A COMMITMENT TO ADOPT A BEHAVIOUR).**
Strategies	– Raise awareness about the need for change by making the risk seem serious and at the same time personally relevant; – Emphasize likely positive results of adopting the recommended action and downplay negative consequences.
CONDITION 2	**THERE ARE NO ENVIRONMENTAL BARRIERS THAT MAKE IT IMPOSSIBLE FOR THE BEHAVIOUR TO OCCUR.**
Strategies	– Identify the obstacles faced by the audience and attempt to remove them; – Create supportive environments.
CONDITION 3	**THE PERSON HAS THE SKILLS NECESSARY TO PERFORM THE DESIRED BEHAVIOUR.**
Strategies	– Specify the recommended action in terms of *how*, *where* and *when,* and provide clear directions and training on how to perform the recommended action; – Identify or provide role models who have succeeded in adopting the recommended action, and ensure they are visible; – Provide suggestions or teach people how to find their own healthier alternatives/solutions to certain barriers; – Teach people how to critically and realistically assess past failures/current relapses so that lessons can be learned and progress continues.

a Examples of mainstream behaviour change theories studied: stages of change/transtheoretical model, health belief model, social learning theory, theory of planned behaviour, etc.

4

CONDITION 4	**THE PERSON BELIEVES THE ADVANTAGES (BENEFITS, ANTICIPATED POSITIVE OUTCOMES) OF THE BEHAVIOUR OUTWEIGH THE DISADVANTAGES (COSTS, ANTICIPATED NEGATIVE OUTCOMES).**
Strategies	– Emphasize likely positive results of adopting the recommended action and downplay negative consequences; – Set up systems of reinforcement through incentives, assistance and regular updates on the given risk and recommended action.
CONDITION 5	**THE PERSON PERCEIVES MORE SOCIAL PRESSURE TO EXHIBIT THE BEHAVIOUR THAN NOT.**
Strategies	– Indentify key influencers/role models who are important to the intended audience, and make the audience feel that these role models support the recommended behaviour; – Identify or provide role models who have succeeded in adopting the recommended action and ensure they are visible.
CONDITION 6	**THE PERSON PERCEIVES THAT THE BEHAVIOUR IS CONSISTENT WITH HIS OR HER SELF-IMAGE AND DOES NOT VIOLATE HIS OR HER PERSONAL STANDARDS.**
Strategies	– Raise awareness about the need for change by making the risk seem serious and at the same time personally relevant; – Help set quantifiable, realistic, graduated and moderately difficult goals within the context of pre-existing goals; – Customize information about risks, benefits and recommended actions, and tailor the intervention to the intended audience's values, standards and situation.
CONDITION 7	**THE PERSON'S EMOTIONAL REACTION TO THE BEHAVIOUR IS MORE POSITIVE THAN NEGATIVE.**
Strategies	– Emphasize likely positive results of adopting the recommended action and downplay negative consequences; – Set up systems of reinforcement through incentives, assistance and regular updates on the specific risk and recommended action.
CONDITION 8	**THE PERSON HAS CONFIDENCE THAT THEY CAN MAINTAIN THE BEHAVIOUR UNDER A NUMBER OF DIFFERENT CIRCUMSTANCES (I.E., THE PERSON HAS THE PERCEIVED CAPACITY TO MAINTAIN THE BEHAVIOUR).**
Strategies	– Specify the recommended action in terms of *how*, *where* and *when,* and provide clear directions and training on how to perform the recommended action; – Identify the obstacles faced by the audience and attempt to remove them; – Provide suggestions or teach people how to find their own healthier alternatives/solutions to certain barriers; – Help set quantifiable, realistic, graduated and moderately difficult goals within the context of pre-existing goals; – Teach people how to critically and realistically assess past failures/current relapses so that lessons can be learnt and progress continue rather than stop.

Adapted from: Hershfield, L. et al. (2004). *Changing Behaviours: A Practical Framework*, The Health Communication Unit at the Centre for Health Promotion, University of Toronto, www.thcu.ca

In order to stimulate reflection and prepare people for a potential behaviour change, they must be adequately informed about the change, and you must be ready to initiate change the moment they are ready to take action. Subsequent to this decision, much effort must be invested to ensure that people stay the course with respect to the desired action and change.

Design a program that reflects the intended audience so that activities are customized to support them through their change process.

4

5

Getting the process started

Generally speaking, implementation follows a different set of steps than the planning process. Drawing on numerous reference documents[2, 9, 10, 11, 12, 13], in this chapter we will present a summary of these various steps to implementation.

> STEP 1: As a director or manager of a healthcare organization, begin by examining and reflecting on the situation.
> STEP 2: Establish a working committee and encourage employee involvement and participation in the process.
> STEP 3: Assess and analyze employee and workplace needs.
> STEP 4: Develop an action plan that corresponds to the identified needs.
> STEP 5: Communicate the action plan and promote activities.
> STEP 6: Evaluate the results and adapt activities.

Upon reading these documents and literature reviews[2, 14, 15], it becomes clear that the essential ingredient in the success of any health promotion initiative is the inclusion and participation of employees (various job categories, hierarchy levels, associations and unions) throughout the process. **Staff and management must work collectively to establish the workplace as a health-promoting environment[15].**

Your approach must be founded on the exchange of knowledge, whereby opportunities are provided to establish a collaborative relationship between employer and employees. It must involve a democratic process that fosters solutions for which there is consensus. In addition to the positive health effects, a health-promoting workplace approach can improve employees' professional satisfaction and morale as well as the quality of their work and productivity, ultimately creating a more favourable social climate and organizational culture.[15] All of these factors contribute to the attraction and retention of healthcare personnel.

An interactive and collaborative process leads to a greater appreciation of problem situations and, consequently, to more appropriate solutions. It also enables the identification of employees' existing needs and the activities that will most effectively meet these needs. In this way, your program will reflect the reality experienced by your employees and integrate elements that members of your staff consider most important. For example, it serves no purpose to invite a speaker to give a talk about stress management if the employees are not interested or do not wish to take part in such an event[2].

Many success factors are presented in this chapter. Of these, your chosen approach should above all reflect a "participatory" nature.

Your approach must be participatory. In other words, it must engage all employee groups throughout the process and promote discussion between employees and managers.

5 Step 1: As a director or manager of a healthcare organization, begin by examining and reflecting on the situation

Before embarking on your implementation, it is important to keep in mind the following recommendations to be followed throughout the process[2, 16, 17].

Recommendations:

> The support and participation of senior management is essential to the success of implementation;
> The participation, commitment and support of managers at all levels must be encouraged by involving them in the process;
> The committee must be dynamic and have strong leadership;
> The approach must be person-centred, confidential and based on trust, not fear;
> The needs, preferences and attitudes of the various participant groups must be taken into consideration;
> The program must take into account the interdependence of the various aspects of health (multi-strategy concept);
> The program must be adapted to the characteristics specific to each work environment and must also ensure that employees will have the time to participate in its activities.

To create an initial profile of your organization and gain a better idea of the issues that merit more attention, certain indicators should be considered. Below are a few examples of such indicators[18, 19, 20, 21].

Indicators:

> Employee turnover;
> Job vacancy rates;
> Training and professional development time;
> Overtime hours;
> Rates of disability leave;
> Frequency and severity of accidents that lead to paid work leave;
> Employee job satisfaction;
> Frequency/rate of having to bring in external workers;
> Absenteeism;
> Percentage of smokers among staff;
> Results of staff surveys on working conditions;
> Analysis of burnout rates.

SUGGESTED READINGS

Canadian Nurses Association. (2002). *Quality of Worklife Indicators for Nurses in Canada, Workshop Report*, presented to the Canadian Council on Health Services Accreditation June 3, 2002, 18 p. www.cna-nurses.ca

Quality Worklife-Quality Healthcare Collaborative (QWQHC). (2009). *A Snapshot of Worklife Measurement in Canadian Healthcare Organizations: Indicator Survey Results*, Accreditation Canada, 17 p. www.qwqhc.ca

Suggestion box[2]:

One of the simplest, most effective and least intrusive ways of gathering the input of employees is to install a suggestion box.

Here are a few relevant tips:

> Inform employees that a suggestion box is going to be installed, and remind them of it throughout the period it is in use;
> Ask for suggestions that pertain to the workplace and professional environment as well as to the employees' health practices;
> Emphasize the fact that all suggestions will be taken seriously and kept confidential;
> Install the suggestion box when most employees are likely to be present (i.e. not during a holiday period);
> Make sure your suggestion box is attractive, visible and easily accessible;
> Make sure that all suggestions are followed up in some way, even if it is only to acknowledge receiving them;
> Consider creating an electronic suggestion box to assure employees of even greater confidentiality (e.g. use of pseudonyms).

Once the organizational profile has been established, you may want to consider involving your organization in a certification or accreditation process. To learn more and be able to make an informed decision about that, we refer you to Part 2, Chapter 2, *Certification and Accreditation… a Framework for Action.*

Step 2: Establish a working committee and encourage employee involvement and participation in the process

5

In certain parts of the world, workplace health and safety laws stipulate the establishment of parity committees to manage certain aspects of health and safety. In health promotion, they are referred to as *ad hoc* committees, and in health and social services organizations, they are increasingly known as workplace wellness committees or healthy work environment committees.

Composition of the committee[10, 12, 14]:

The committee must be representative of the organization's staff as a whole. It must have representatives from different employee groups (e.g. job categories, work shifts) various hierarchical levels (notably from the management team), and other groups (e.g. unions, professional associations, etc.).

The size and membership of the committee members is not fixed and must be adapted to the scope of the project and size of the organization. For example, the makeup of a steering committee charged with coordinating a global health promotion initiative encompassing the entire establishment would not be the same as that of a working committee whose objective is to promote a physical activity.

When selecting committee members, the person in charge should consider the potential committee members' interest in the matter at hand, their credibility in the workplace and their skill sets.

As an example, here are some general categories to consider:

- Employees: the committee must be representative of the various employee groups (job category, position level, work shift). However, depending on the goals of the project and the target population, it may be appropriate to bring together only a subset of employee categories;
- Union representatives;
- Health and safety committee representatives;
- Professional representatives;
- Head(s) of the department(s) in question;
- Members of senior management (e.g. those responsible for planning, budgets, healthcare, etc.);
- Health promotion advisors;
- Managers of quality assurance departments;
- Human resources department members;
- Public information officers;
- Any other person whose involvement is considered of value;
- When and as needed, external consultants or researchers can be involved in planning, meeting facilitation or report writing (according to budget, priority given to the project, etc.).

Role of the committee:

In accordance with its mandate and objectives, the committee must create a profile of the existing situation and highlight its strengths and weaknesses. It must then develop a multi-strategy, integrated action plan, encompassing a variety of activities that address the identified weaknesses. Subsequently, it must see to the implementation and promotion of the program. Lastly, it must review the actions taken and make any modifications necessary.

Encourage employee involvement[2]:

To inspire staff commitment in the process, it is important to adhere to the following guidelines:

- Exercise committee management that is dynamic, participatory and enthusiastic and that encourages interaction among members;
- To ensure staff of the continuity of the process, it is important to name a "champion" who could take over the work in the event of the departure of the person in charge;
- Follow up on progress made and propose incentives (see Step 4, p. 33);
- Take measures to ensure the allocation of time for employees to participate in the process;
- Continuously promote the benefits of a healthy workplace: organize events, post information or engage in informal discussions with staff.

5 Step 3: Assess and analyze employee and workplace needs

A number of different yet complementary methods can be used to assess needs, depending on the situation. More detailed information on the issues specific to each theme is presented in the various chapters of Part 3 – Themes.

Needs assessment methods:

> Statistical data: data/indicators already compiled in reports (the organization's annual report, quarterly score cards, internal information systems, regional databases, etc.). These data can be compared with those from previous years, those from another similar institution, or against current standards;
> Reports: qualitative information may exist in reports that are already available (reports from the quality management committee, health and safety committee, professional associations, unions, etc.);
> Direct consultation with employees[10] : several methods can be used to this effect:
  • One-on-one meetings;
  • Group discussions;
  • Questionnaires;
  • Surveys.

In the case of surveys, there are four factors that contribute to maximizing the response rate: promoting the survey before it is distributed, guaranteeing the confidentiality of all responses, freeing up the time required for employees to complete the survey and sending out reminders to return it, and identifying the best time to distribute the survey (e.g. the most opportune time of year, coordinating the survey with a promotional event or social gathering, etc.)[22].

For each needs assessment method, certain factors must be taken into account:

Factors[2]:

> Literacy levels[b] : Who is the target audience? What means will best ensure that you are understood by your employees? What is their literacy level?
> Cultural mix: men, women, ethnic groups, etc. In some cases, it may be appropriate to organize separate meetings for men, women or different ethnic groups (See Part 3, Chapter 4: *Taking Action to Reduce Social Inequalities in Health in the Workplace*, p. 138);
> Work shifts: how to get input from the largest number of people?
> Confidentiality;
> Time available: allocate time to employees to enable them to participate in the assessment activities;
> Employees who are absent or on sick leave: everyone's opinion matters. Devise a way to reach people who are absent or on sick leave;
> Available communication tools: what communication tools can be used?
> Access to a computer: do your employees have easy access to a computer? How will you communicate with them?
> Urgency: in the current workplace situation, is there a feeling of urgency to take action? The answer to this question will determine whether you select assessment methods that take place over a short or long period.

b Literacy levels: Are all members of our staff capable of reading the language used in the workplace? To what extent? Is it better to communicate with them in writing, by e-mail or by organizing a staff meeting?[2]

Step 4: Develop an action plan that corresponds to the identified needs

5

In addition to incorporating your employees' general concerns, your action plan must account for the diversity of your personnel by proposing actions adapted to their[2] :

> Current health status;
> Literacy levels;
> Cultural group;
> Social customs;
> Skills.

In this way, you will ensure that you meet individual needs while taking care to diminish rather than exacerbate any potential social inequalities in health within your organization.

Furthermore, it is important to put measures in place that will enable employees to find the time to participate in the activities. Sometimes activities may need to be adapted or special arrangements made for certain employees, with the agreement of their respective department managers and the human resources department.

The activities proposed must, whenever possible, make use of the human and material resources available on site (rooms, facilities, equipment, etc.). The person in charge of the program must ensure that any additional necessary resources (financial, human) be allocated by the healthcare organization's senior management, as agreed upon beforehand. It may also be possible to create a partnership between the program and a foundation, community or private business to obtain additional resources and greater visibility. That being said, it is important to bear in mind that many activities can be carried out using minimal financial resources.

The introduction of incentives is an additional motivational tool that can be used with employees (see *Initiating the Change*, p. 26). Such incentives or rewards can be intrinsic (the satisfaction of making progress or learning a new vocabulary that facilitates communication and the concerted search for solutions; the satisfaction of knowing that you are involved in something that is moving in a positive direction and of seeing problems become resolved) or extrinsic (special recognition at a closing event or in the organization's internal newsletter, rewards such as gift certificates, sports items or free admission to an event). These incentives can be awarded for simply attending an event (e.g. door prize) or for achieving an established objective[4, 23].

The action plan must contain the following elements:

> An overview of what you have learned from the needs assessment;
> Identification of problems/needs;
> Prioritization of problems/needs;
> Actions chosen to address the identified problems/needs;
> Each action must have:
  • A person to be "in charge"
  • Objectives
  • Communication modes
  • Evaluation methods
  • A schedule
  • Necessary resources (available and desired)
> Global communications plan;
> Global evaluation;
> Global timeline for the action plan with short-, medium- and long-term goals;
> Global budget and necessary resources.

Evidence:

When developing your activities, it is important to refer as much as possible to scientific evidence, examples of best practices, or projects that have been the subject of a full and detailed evaluation. Wherever possible, propose activities to your employees that have been found to yield the best results.

Objectives:

The objectives of each intervention must be clear and measurable in order to focus people's best efforts. This exercise will push you to invest the necessary energy to communicate and promote the activity and ensure the established goals are met. A good way to verify that the objectives are appropriately adapted is to compare them to the **SMART**[10] principle below:

S – Specific
M – Measurable
A – Action-oriented
R – Realistic
T – Time-based (framed in a set timeline)

5

Evaluation – monitoring:

Although evaluation is the subject of Step 6 of the implementation process, it must be envisaged at the stage when you are creating the action plan. Indeed, the objectives must be measurable in order for them to be evaluated.

Moreover, while the evaluation is typically conducted at the end of a project, you may want to conduct one partway through the activity (monitoring). With the help of some easily assessable indicators (participation rates, satisfaction levels, etc.), you will be able to modify the activity while it is in progress to better adapt it to the needs of the target group.

Throughout the creation of the action plan, it is important to keep the following factors in mind:

> Are employees the focus of the initiative? You must ensure that the program integrates elements that employees have identified as being important to them.
> Is the action plan in line with the existing values and culture of the organization? Is it necessary or feasible to define the organizational values beforehand?
> Are there any foreseeable obstacles?
> Have adequate time and realistic resources been planned for the implementation of this project? What resources or assistance will you need in order for your team to succeed?

Step 5: Communicate the action plan and promote activities

All communications activities should support and enhance the program's visibility and scope. The greater the number of employees who know about the program, the greater the chances are that it will succeed. Communications activities must therefore not be neglected.

Communicate the action plan[12]:

Regular communication with your employees to stimulate their engagement and participation in your healthy workplace initiative will pay off. As such, the major goals and strategies of the action plan could be presented to staff at a special meeting. In that case, it would be useful to plan for a suggestion and comments period or create a document that would allow the attendees to express their thoughts in writing. Furthermore, the organization's existing internal communication tools (internal newsletter, intranet, etc.) can be used to circulate documents and gather comments and suggestions.

Communication modes must also be established in order to reach the evening and night shift workers, employees working from a remote site or those who are absent (e.g. extended leave, sick leave). For example, information can be communicated via email, telephone or in a notice attached to the paystub.

Once you receive the comments and suggestions, you will be ready to proceed with implementing your action plan and able to make changes if needed.

Promote the activities[10]:

Communicating the various initiatives and activities is of vital importance when implementing the program in order to spur employee participation.

If you are aiming for a high participation rate, you will need to prepare a communications plan detailing which communication mechanisms are to be used for each activity.

Communications must be **adapted to the target audience** and include the following elements[10]:

> Description of the event;
> Logistical information: place, date and time, duration;
> Identification of whom the activity is targeting;
> Eye-catching invitation (colour, images, themes, etc.)

The communication methods used must take into account the literacy levels, cultural diversity and work schedules of the target audience.

For illustrative purposes, below is a list of the most frequently used communication modes[10] :

Verbal:

> Message from the senior executive (Director, CEO, President);
> Information meeting with managers or a series of meetings with staff;
> Team meeting;
> Launch event (e.g. theme of the month).

Written:

> Internal communiqué;
> Postings on notice boards, lockers;
> Message on the intranet site;
> Information distributed with paystubs;
> Small information materials (e.g. cards) placed on cafeteria tables and in staff lounges;
> Business card-sized reminders distributed to personnel;
> Video or audio clips sent to employees by email.

Non-verbal:

> Day-to-day actions or behaviours that reinforce the message established by senior management or the program implementation committee. For example, a manager registering for an activity, using the new equipment or adopting the new operating methods (e.g. bicycle shelter, exercise facility, carpooling, recycling).

Step 6: Evaluate the results and adapt the activities

Many methods of evaluation exist and are detailed in reference books. These methods are often complex and are mainly used by researchers. To guide you in your evaluation process, we propose a basic framework that integrates the principles and criteria recognized in these reference works.

Program evaluation is a major step that is all too often neglected. Historically, this step has primarily been carried out to determine whether a program is effective or not. Today, program evaluation is used more to ensure continuous quality improvement—in other words, to determine what is and is not working, why, and what changes need to be made[13]. A great deal can be learned from this exercise, which will serve not only to enhance the activities that are already under way, but to improve other similar projects as well[14].

Beyond the goal of continuous improvement, an evaluation may be undertaken for the following reasons[24]:

> To gather evidence of the effectiveness or impact of a program;
> To be accountable to stakeholders: funders, clients, volunteers, staff, or communities;
> To compare a program to other programs;
> To assess the efficiency of a program (cost-benefit analysis);
> To test a hypothesis for research purposes.

The evaluation process, as with all other aspects of the health promotion initiative, must endeavour to encourage the participation and involvement of employees[13].

“Fundamentally speaking, to conduct an evaluation is to judge the value of an initiative by carrying out a test that is capable of yielding scientifically valid and socially legitimate information with respect to the activity or any of its components. The goal is to ensure that the various stakeholders involved, whose judgment criteria can sometimes differ, are able to determine their position on the initiative so they can individually or collectively establish a judgment that can be translated into actions.” (Brousselle, 2009)[25].

An evaluation must be conducted for each intervention included in the action plan. It can be carried out while the activity is in progress, in the case of a longer-term project, or after the activity has ended if it is of shorter duration. The advantage of a mid-term evaluation is that the results can be used to bring immediate improvements to the activity.

5

Furthermore, with the participatory implementation model, it is essential to disseminate evaluation results, as well as any decisions made with respect to these results, to the organization's employees[26].

Various authors propose different kinds of evaluations. In this Guide, we have retained the assessment types advanced by Brousselle et al. (2009), who state that "an intervention, whatever its nature, can be the subject of two types of evaluation: a **normative assessment** or **evaluative research**."

Normative assessment

Normative assessment compares each of the components of an intervention with criteria or norms. It is thus a process of verifying to what degree the intervention components conform to certain standards[25]. In this way, it allows one to determine the degree of success of an activity.

At a minimum, the following elements should be evaluated:

> Activity completion (100%, 50%, 0%);
> Participation rate;
> Satisfaction of participants;
> Achievement of established objectives (hence the necessity to formulate "SMART" measurable objectives).

Evaluative research

Evaluative research uses a scientific process to analyze and understand the causal relationships between different components of an activity[14]. It is a methodology that investigates the *how* and *why* of the results[26], and is based on comments and impressions of how a given activity has been carried out. As such, it can lead to a better understanding of the reasons for success or failure, which are often related to behaviours, attitudes or complex interactions.

At a minimum, this type of evaluation should examine the following elements:

> Reasons why the activity did not turn out as predicted in the action plan;
> Reasons for participant dissatisfaction;
> Facilitative factors;
> Main obstacles encountered;
> Improvements that can be made to the activity in progress or to a similar activity in the future.

In addition, evaluative research can be divided into six categories of analysis that call for different research methods. Each research method is used to analyze one specific program element: **strategic analysis** looks at the relevance of the program or intervention; **logical analysis** examines consistency (soundness and operational validity); **production analysis** considers productivity and the determinants of a successful process; **effect analysis** validates the effectiveness of a program; **efficiency analysis** looks at the overall efficiency of the action; and **implementation analysis** assesses how the program interacts in various ways with the implementation context[25].

Over the longer term, it is a good idea to assess the impact of the program on the health and well-being of employees. To do so, you can use the same indicators on which your initial examination as a manager was based (See *Step 1: As a director or manager of a healthcare organization, begin by examining and reflecting on the situation* p. 30), such as employee turnover, job satisfaction, and absenteeism rates, etc. This will allow you to do a before-and-after comparison and get an overall sense of the success of your program.

SUGGESTED READINGS

Brousselle, A., et al. (2009). *L'évaluation: concepts et méthodes* [Evaluation: concepts and methods], Montréal: Les presses de l'Université de Montréal. 304 p.

O'Donnell, M. (2002). *Health promotion in the workplace*, Delmar, 614 p.

The Health communication unit. (2007). *Evaluating Health Promotion Programs Workbook*. The Health Communication Unit at the Centre for Health Promotion, University of Toronto, v3.6, august 2007, 100 p. www.thcu.ca

World Health Organization Europe WHO. (2001). *Evaluation in Health Promotion, Principles and Perspectives*, WHO Regional Publications, European Series, N° 92, 561 p. www.euro.who.int

Additional tools

6

The online health planning tool produced by the Health Communication Unit and the National Collaborating Centre for Methods and Tools

The website of the University of Toronto's Health Communication Unit offers an online tool to plan health promotion programs, which is accessible in French and English. This tool was created in collaboration with the National Collaborating Centre for Methods and Tools, one of six national collaborating centres in public health in Canada (www.nccmt.ca).

This online planning tool proposes a six-step process: **1.** Project Management; **2.** Situational Assessment; **3.** Set Goals, Audiences, and Outcome Objectives; **4.** Choose Strategies and Activities and Assign Resources; **5.** Develop Indicators; **6.** Review the Plan.

The tool guides you through these six steps by asking you a set of questions to guide you through at each step.

In addition, this website provides a number of resources, including:

- Worksheets to direct your data gathering, choice of strategy, choice of indicators, etc.;
- Examples of completed worksheets and six-step plans;
- A selection of recommended resources to help you with decision-making at each step of the process (the documents are directly accessible from the website);
- Practical tips.

For the online planning tool, please go to: www.thcu.ca/ohpp.

The Wellness Council of America's Checklist

The website of the Wellness Council of America (WELCOA) contains numerous online tools, including, in particular, the Well Workplace Checklist. This is an interactive assessment instrument that allows organizations to evaluate their workplace health promotion programs based on seven keys to success developed by the organization.

Depending on the results obtained in each category, advice and suggestions are provided to help managers improve their programs.

Here is the link to WELCOA's website, where you can access the checklist: www.welcoa.org/wellworkplace

Certification process

There are many certification programs with highly detailed procedures to help you achieve your objectives. Various types of support materials are available: handbooks, DVDs, various accessible planning tools, standards to be complied with, evaluation visits, reports, recommendations, etc.

For more information on this subject, please refer to Part 2, Chapter 2, *Certification and Accreditation… a Framework for Action*.

7 Additional examples

Examples from the Quality Worklife–Quality Healthcare Collaborative Summit 2010

The theme of the Quality Worklife – Quality Healthcare Summit 2010 was **Healthy Workplaces in Action: Working Together to Deliver Quality Care**. On this organization's website, you will find links to some 10 presentations that were given at this event. Each presentation relates an experience in the design and implementation of a participatory healthy workplace promotion initiative carried out in a different Canadian province. A summary of each presentation is provided in the 2010 Summit Program.

Suggested website:
www.qwqhc.ca/summit-2010.aspx

Three projects in Quebec (Canada): CSSS, Rehabilitation Centre, University Institute

Below we give three examples of participatory healthy workplace promotion initiatives in three types of healthcare settings in Quebec: the Workplace Improvement Committee of the CSSS de Bordeaux-Cartierville-Saint-Laurent (Montreal), the Workplace Health and Wellness Program of the CRDI Gabrielle-Major (Montreal), and the Health Promotion Institute of the University Mental Health Institute of Quebec (Quebec city).

These three initiatives were carried out in distinctly different organizations with profiles, challenges, and contexts that are unique to each. As such, the projects undertaken had different goals to address the particular issues identified in each setting. Nonetheless, a common thread ran through all three examples with respect to the prerequisites for the success of this type of project: the participation of all employees and strong support from senior management.

Projects

Three projects in Quebec (Canada)

Workplace Improvement Committee **– CSSS de Bordeaux-Cartierville-Saint-Laurent – Montreal, Canada**

This project relied on the commitment and creativity of its employees. The CSSS decided to undertake an extensive consultation exercise in order to identify the main actions that would enable the centre to achieve the title of "Employer-of-choice" within two to three years. Five panels were established on the following themes: 1. Attraction and retention; 2. Working conditions; 3. Professional development; 4. Recognition; 5. Specific needs of managers.

(See Project Description Nº 1).

Workplace Health and Wellness Program **– CRDI Gabrielle-Major – Montreal, Canada**

This program was aimed at linking a healthy workplace to the quality of work life. Specifically, it encompassed all of the factors through which an individual can derive satisfaction from, and be motivated by, his or her workplace and engage in activities that promote overall health and well-being. This *workplace health and wellness program* is an integral part of the organization's global strategy to address absenteeism and promote a healthy workplace.

(See Project Description Nº 2).

The Health Promotion Institute **– University Mental Health Institute of Quebec City – Quebec City, Canada**

This project based itself mainly on the HPH (Health Promoting Hospitals) model of a comprehensive and proactive approach to health. The initiative there was enhanced by the adoption of a variety of other approaches, including: Planetree, BNQ standards, and Health Canada's Workplace Health and Wellness Program.

(See Project Description Nº 3).

A project in Ontario (Canada)

Project

Kailo Workplace Wellness Program **– Halton Healthcare Services (HHS) – Oakville, Canada**

Kailo is a best-practices–based employee health promotion program, originally developed at the Mercy Medical Center in Iowa (United States). This program has been recognized for its excellence by several international and American associations (the Joint Commission for Accreditation of Healthcare Organizations, Wellness Councils of America, and the American Hospital Association). This approach is based primarily on psychosocial factors such as stress management, work–life balance and employee satisfaction. HHS conducted a survey of its employees, which led to the identification of five main objectives. The Kailo approach was chosen to target three of these objectives: 1. Involving employees in improving the quality of work life; 2. Encouraging open dialogue and ensuring that information is communicated effectively; 3. Supporting and encouraging employees to make healthy lifestyle choices. The initiative was implemented by a Kailo coordinator, in collaboration with HHS managers.

(See Project Description Nº 4).

7

FIND OUT MORE

Wellness Council of America (a resource for workplace wellness in America) www.welcoa.org

Health Canada. (2008). *A Guide to Developing and Implementing the Workplace Health System in Medium and Large Businesses*. www.hc-sc.gc.ca

Health Canada. (2009). *Health Works Guide: A How-To for Health and Business Success*, 24 p. www.hc-sc.gc.ca

O'Donnell, M. (2002). *Health Promotion in the Workplace*, Delmar, 614 p.

The book entitled *Health Promotion in the Workplace* presents a detailed overview of the workplace health promotion field and includes topics such as: health benefits and financial gains; the design, management and evaluation of programs; awareness-building strategies; theories of behaviour change; and key points about programs that target specific lifestyle habits.

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Chapter 2

CERTIFICATION AND ACCREDITATION… A FRAMEWORK FOR ACTION

Key Points

"Employer-of-choice"[a] – type strategies provide a means for healthcare institutions to work toward improving quality of care and services as well as achieving employee attraction and retention objectives.

Certification affords several advantages to the institutions that seek it, including: recognition for their actions and commitment, development of a global or integrated vision of health and management, and a road map for establishing an action plan with clear objectives.

Certain certification programs or strategies are comprehensive and allow one to take action at various levels of a healthcare organization, while others more specifically target employee and workplace health.

The choice of a certification program must be based on the needs and reality of the healthcare institution (e.g. the objectives of the program correspond to the action priorities; the time and costs involved match the resources available).

The institution's senior management must establish an overarching vision of the needs and ensure that the various certification processes undertaken are consistent with each other and align with this global vision.

1 Introduction

Over the past 20 years, the quality of healthcare and social services in developed countries has become an issue of constant and pressing concern to patients, employees and decision makers alike[(1)]. This demand for quality calls for serious attention, and it is in this context that the many types of certification and accreditation processes have emerged.

Providing safe, quality healthcare to patients is challenging and complex, as it hinges on, among other things, the health and well-being of staff, close ties with the community, and sustainable development practices. In a context of personnel shortages and an aging workforce, strategies of the *"employer-of-choice"* type are becoming increasingly popular.

There are a number of tools that offer a framework for the programs and initiatives implemented by healthcare organizations: the accreditation process, obtaining certifications, or subscribing to a network or care philosophy. Such tools provide a clear structure for the initiative itself and for maintaining the momentum of the change process (individual and organizational). Furthermore, these validation tools afford the organizations a level of recognition for their actions and commitment.

In this chapter, we will describe several certification and accreditation processes as well as other types of initiatives whose aim is to develop healthy workplaces.

a "Employer-of-choice"® is a program that recognizes the excellence of certain organizations or companies as employers. The term used throughout the Guide refers to this type of recognition or certification.

2 Definitions[2]

Accreditation

Accreditation is a formal process by which a recognized body, usually a non-governmental organization (NGO), assesses and recognizes that a healthcare organization meets applicable predetermined and published standards. An accreditation decision about a specific healthcare organization is made following a periodic on-site evaluation by a team of peer reviewers. Accreditation is often a voluntary process in which organizations choose to participate, rather than one required by law and regulation.

Certification

Certification is a process by which an authorized body, either a governmental or non-governmental organization, evaluates and recognizes either an individual or an organization as meeting predetermined requirements or criteria. Although the terms accreditation and certification are often used interchangeably, accreditation usually applies only to organizations, whereas certification may apply to individuals as well as organizations. When applied to an organization, or part of an organization, certification usually implies that the organization has additional services, technologies, or capacities beyond those found in similar organizations.

3 Advantages of certification for a health organization

"Standards facilitate the planning and implementation of preventive programs by providing a hierarchy of measures to take and a framework with which to ensure objectives are being met."

– Guylaine Bourque (*Synergie*, Association Québécoise d'établissements de santé et de services sociaux, June 2009)[3]

According to the Bureau de normalisation du Québec (BNQ) [Quebec Standards Bureau], certification programs allow organizations to be recognized for their ongoing compliance, in terms of services and processes, with current standards or other recognized documents, and—especially where healthcare organizations are concerned—to remain competitive in terms of workforce recruitment[4].

Many studies have shown that accreditation processes generally facilitate the introduction of changes aimed at improving the quality and safety of care within healthcare institutions. They are particularly effective tools for integrating continuous quality improvement measures, fostering a spirit of cooperation, strengthening ties among healthcare workers, and creating new leadership for quality improvement initiatives[5].

The various certification and accreditation programs described in this chapter demonstrate the benefits of such processes, not only for the organization, but also for its staff and clientele. Here are some of those benefits[b]:

Benefits for the organization, its employees, users and partners

- Foster the development of a global and integrative approach to healthcare and management;
- Provide a road map for establishing an action plan with clear objectives;

b This list of benefits is mainly derived from the standards manual of the International Network of Health Promoting Hospitals and Health Services, the GP2s handbook for the Healthy Enterprise standard and information from the websites of Accreditation Canada and the Conseil Québécois d'agrément (Quebec Accreditation Council).

3

- Improve the quality and safety of healthcare services as well as overall performance;
- Ensure the continuous improvement of its operations;
- Demonstrate the commitment and efforts invested by the organization in achieving a high standard of care;
- Strengthen employee commitment, motivation, and sense of responsibility;
- Provide the organization with a framework for improving the quality of life of its employees;
- Represent an effective means to showcase the organization and attract qualified personnel;
- Identify the organization's unique characteristics and strengths, as well as the weaknesses that need to be addressed;
- Reinforce the organizational culture;
- Improve the overall satisfaction of patients and partners;
- Provide access a variety of tools;
- Boost the "organizational image" and the position of the facility within its milieu and with respect to its partners.

Why adopt an "employer-of-choice" strategy?

a) To establish an integrated vision:

- Management of organizational health:
  - Align the culture with the business strategy;
  - Engage employees.
- Management of individuals' health:
  - Promote health and preventive healthcare;
  - Facilitate the return to work.

b) Numerous studies have demonstrated that a high level of employee engagement favours the following outcomes:

- Attraction and retention of personnel;
- Employee morale;
- Productivity[6].

4

Deciding whether to embark on a certification process

Embarking on a certification process requires an integrative management approach with a clear picture of the organization as a whole and of all of its facets, as well as the dynamics that unify these facets.

While such a management model is conducive to the introduction of new systems, it is important to evaluate the organization's capacity to integrate a new certification "component" by considering the following points ahead of time:

- Level of certification targeted;
- Organizational politics and culture;
- Level of expertise required;
- Legal and regulatory requirements;
- Objectives of the integration project;
- Management of stress associated with the change;
- Availability of necessary resources.

As with any organizational change, a critical factor to consider is senior management's commitment to the certification or accreditation process.

Which program to choose?

Here are a few factors to guide your selection of certification or accreditation programs:

- The objectives of the certification program in relation to local, regional and national action priorities;
- Time investment required to obtain certification;
- Costs associated with the certification program;
- Organizations that are already certified;
- Duration of the certification (time before expiry/renewal);
- Availability of support mechanisms (e.g. guidance, financial support, networking).

5 Do you need more than one type of certification?

Most certification processes complement each other and can thus be combined without necessarily duplicating efforts or resources.

Some measures are designed to support the development of a global or integrated vision of health for patients, users and their families, healthcare workers and communities, while others have a more specific focus (e.g. the development and maintenance of healthy workplaces).

There are "employer-of-choice" strategies that offer health organizations a means of attaining their workforce attraction and retention objectives. Such strategies generally include the following components: professional development opportunities, innovative practices, occupational health and safety policies, employee recognition programs, employee-defined values, and opportunities for career advancement[7].

When more than one certification process is undertaken, it is important that they tie in with each other and with the organization's vision as a whole.

6 Types of certification and accreditation

As we have just seen, some certification programs are comprehensive and encompass several dimensions of the healthcare organization, while others address specific parts of an organization's overall mission. Furthermore, there are certification programs that exist at the regional, national and international levels. Examples of all of these types of programs will be described in the following pages.

6.1 Comprehensive health certification and accreditation programs

6.1.1 Membership in international organizations

The International Network of Health Promoting Hospitals and Health Services (HPH)

Description

In 1993, the World Health Organization (WHO) instituted the HPH network with the goal of integrating health promotion, education, disease prevention and rehabilitative services into healthcare services. To date, the International HPH network boasts more than 800 members, hospitals and healthcare services, and 38 national and regional networks in over 40 countries. The HPH network's activities are centred on the patient, the employee, the community, and the hospital or health services centre as an organization. Its member institutions adhere to the principles stated in the Ottawa Charter for Health Promotion (1986), the Budapest Declaration on Health Promoting Hospitals (1991), the Vienna Recommendations on Health Promoting Hospitals (1997), the Bangkok Charter for Health Promotion (2006), and the Standards for Health Promotion in Hospitals (2004).

6

Mission

The International Network of Health Promoting Hospitals and Health Services works toward incorporating the concepts, values, strategies and standards or indicators of health promotion into the organizational structure and culture of the hospital or health service. The goal is to maximize health gain by improving the quality of healthcare, the relationship between hospitals or health services, the community and the environment, and the conditions for and satisfaction of patients, relatives and staff.

Objectives

> To provide leadership on matters critical to health promotion in hospitals and health services and engage in partnerships where joint action is needed;
> To shape the research agenda and stimulate the generation, translation and dissemination of valuable knowledge;
> To set norms and standards and promote and monitor their implementation;
> To articulate ethical and evidence-based policy options;
> To provide technical support, be catalysts for change, and build sustainable institutional capacity;
> To monitor the development of health promotion in hospitals and health services.

Types of membership/certification

The HPH network does not currently officially offer certification, but rather proposes a self-assessment process based on a set of standards and sub-standards as well as a series of indicators against which to measure health processes and outcomes. An organization becomes a member of this network through an official commitment signed by its highest level of authority, to the effect that the organization will endeavour to integrate the HPH-WHO standards.

The five standards established by the HPH network and the WHO are as follows:

> Standard 1: Develop a management policy;
> Standard 2: Assess patients' needs in terms of health promotion;
> Standard 3: Act on behalf of the patient's health promotion needs;
> Standard 4: Create a healthy workplace;
> Standard 5: Collaborate continuously with other healthcare institutions and with the community.

Membership to the HPH network brings with it many advantages for the staff of healthcare organizations. Indeed, instilling a culture of health promotion and implementing health strategies in the workplace benefit all employees.

FIND OUT MORE

International HPH network website:
www.hphnet.org

For more information on the WHO-HPH standards, we recommend reading the document: *Implementing Health Promotion in Hospitals: Manual and self-assessment forms*, WHO Europe, 2006. It is accessible online at the following address:

English version:
www.euro.who.int/__data/assets/pdf_file/0009/99819/E88584.pdf

PLANETREE

Description

Planetree is a not-for-profit organization whose aim is to promote "the development and implementation of innovative models of healthcare." Founded in 1978, its head office is located in Derby, Connecticut (USA). The stated goal of Planetree is to improve patient care through practices that are person-centred. This organization takes its name from that of the tree under which Hippocrates sat while he taught medicine.

Planetree uses a patient-centred approach and has developed its patient-care concept around a set of 10 components that its member institutions must adhere to:

1. Importance of human interaction in creating a healing environment;
2. Importance of family, friends and social support for patients;
3. Importance of education and access to information;
4. Importance of nutrition and the nurturing aspects of food;
5. Importance of a physical environment conducive to healing and well-being;
6. Importance of arts and entertainment to enhance the clinical environment;
7. Importance of spirituality in healing the whole person;

8. Importance of the human touch in treating pain, illness and stress;
9. Importance of and openness to the use of complementary therapies;
10. Importance of healthy communities – extending the boundaries of healthcare to include the larger community.

Type of membership/certification

An organization wishing to become a Planetree institution must undergo a certification process to demonstrate its integration of practices that embody the above priorities. Organizations can become an affiliate member or a designated member. Designated members are affiliate members that, following an assessment conducted by the Planetree network, receive a certification of quality in recognition of the institution's excellence in developing and implementing a culture of person-centred care, service and management.

In Planetree's view, adopting this model affords member institutions credibility in their capacity to deliver patient-centred care. It gives the organization regional and international recognition. With the prestige and recognition that Planetree membership brings to healthcare organizations, Planetree Quebec believes that it's member institutions have a distinct competitive advantage at a time when there is a shortage in the workforce.

FIND OUT MORE

Planetree website: www.planetree.org

The HPH and Planetree models complement each other. Together, the two constitute a winning formula for establishing a healthy workplace, by combining workplace health and safety, modifications to individuals' behaviours and improved organizational practices[8].

These models facilitate the integration of new care and services in healthcare institutions. They also make for an effective combination of promotion and prevention in the delivery of safe, quality healthcare services. A comparative analysis of the two models, entitled *A Comparative Analysis of the International Network of Health Promoting Hospitals and Health Services (HPH) and Planetree Inc.,* is available at www.hps.santemontreal.qc.ca.

6.1.2 Accreditation

One way to improve the quality and safety of care in healthcare organizations is through accreditation. Accreditation consists of a rigorous external evaluation process that includes a self-assessment against a set of standards, an on-site evaluation, a report with or without recommendations, and the awarding or refusal of accreditation. Canadian and international research has shown accreditation to be an effective catalyst for implementing initiatives of continuous quality improvement. In particular, accreditation leads to an increased use of indicators, promotes effective management of change, and improves team communication[9].

In countries such as the UK, US, Australia, New Zealand and Canada, sophisticated accreditation organizations have established themselves with the mission of evaluating hospitals and, in certain cases, community-based healthcare delivery.

In general, they are national and international not-for-profit organizations that offer healthcare institutions a standards-based, external peer-review process in order to assess and improve the quality of patient care provided. The programs and strategies proposed by these organizations have been helping healthcare facilities promote the quality and safety of care for a number of years.

Working in collaboration with their clients, these organizations use a continuous improvement approach without being prescriptive. Accreditation is not a test that one passes or fails, but rather a support mechanism designed to set health organizations up for success.

Accreditation programs are by and large adaptable and take into account the regional culture. The timeline for completing an accreditation cycle or program varies and can be adapted to the client's level of preparedness.

6 Other organizations that offer accreditation

Accreditation Canada

Accreditation Canada is an independent, not-for-profit organization that provides national and international healthcare institutions with an external peer-review process to assess the quality of services they provide to their patients based on standards of excellence. Accreditation Canada is itself accredited by the International Society for Quality in Health Care (ISQua).

On Accreditation Canada's website, there is a list of accredited healthcare organizations, along with documentation and databases of best practices that have been noted in organizations during accreditation survey visits. These practices are models of leadership and superior quality service delivery. It is possible to view the database for projects pertaining to human resources and workplace safety.

FIND OUT MORE

www.accreditation.ca

The Australian Council on Healthcare Standards (ACHS)

Providing internationally recognized accreditation and quality improvement services for healthcare organizations, ACHS is Australia's leading healthcare accreditation provider. In June 2005, the ACHS established ACHS International Pty Ltd to deliver programs and services internationally.

ACHS International delivers accreditation and quality improvement programs for healthcare organizations, offers a comprehensive clinical indicator program, provides consultancies for the development of local accreditation programs and undertakes tailored reporting and analyses.

FIND OUT MORE

www.achs.org.au

Taiwan Joint Commission on Hospital Accreditation (the Commission)

According to the Commission's website, Taiwan was the fourth country in the world to have initiated an accreditation project and the first one in Asia. The Commission launched on-site accreditations in district hospitals in 1999. Its activities then expanded in 2000 to include the accreditation of regional hospitals, district hospitals and psychiatric hospitals. In 2004, the Commission further broadened its scope by issuing accreditations to medical centres.

FIND OUT MORE

www.tjcha.org.tw/S_english.asp

The International Society for Quality in Healthcare (ISQua) is a not-for-profit, independent organization that has members in over 70 countries. ISQua offers services to help health professionals, providers, researchers, agencies, decision makers and consumers achieve excellence in the quality of health services, and to ensure continuous improvement in the quality and safety of healthcare provided worldwide.

The International Society for Quality in Health Care (ISQua) launched its International Accreditation Programme (IAP) in 1999. This is an international program that "accredits the accreditors." As of December 2009, ISQua had accredited 16 organizations.

The Australian Council on Healthcare Standard (ACHS), the Irish Health Service Accreditation Board (IHSAB), Accreditation Canada and the Taiwan Joint Commission on Healthcare Accreditation (TJCHA) are all organizations that have received ISQua Accreditation.

FIND OUT MORE

www.isqua.org

6.2 Employee and workplace health certification

Magnet hospitals

Description

Launched in the early 1980s, the Magnet Recognition Program® aims to distinguish those hospitals that integrate the best practices in recruitment and retention of nursing staff. Magnet facilities have proven to be as exemplary in the standard of patient care they deliver as they have been in addressing the retention factors that nurses have identified as being most important.

The various studies that have evaluated the effectiveness of Magnet hospitals have revealed the following key success factors[10, 11]:

1. Professional autonomy;
2. Administration that backs and supports favourable working conditions;
3. Excellent collaboration between physicians and nurses;
4. Professional validation and nursing leadership;
5. Positive relationships among peers/colleagues;
6. Adequate staffing ratio;
7. Client-centred;
8. Focus on quality.

Type of membership/certification

A hospital that wants to become recognized as a Magnet facility must be prepared to commit to an application and review process. As a first step, the hospital applies to the certification program. The hospital must then submit documentation, providing evidence of how it delivers superior patient care. This self-study is then followed by a multiple-day visit by Magnet program appraisers and an analysis of all the documentation. Subsequently, official Magnet representatives visit the hospital and, if the institution satisfies all Magnet standards, it will earn recognition as a Magnet hospital, which generally entitles the organization to advertise this badge of honour for four years.

FIND OUT MORE

www.nursecredentialing.org/Magnet.aspx

"Employer-of-choice" competitions

Like certification programs, competitions between organizations provide an opportunity to:

> Mobilize all levels of an organization;
> Make comparisons between each level;
> Measure employee satisfaction and engagement;
> Measure the outcomes of actions;
> Boost motivation;
> Promote the organizational culture;
> Raise the organization's profile.

Examples

Hewitt Associates, HR consulting firm
Best Employer Studies

Hewitt is one of the world's largest HR outsourcing and HR consulting firms, with offices in 33 countries. Hewitt's Best Employer Studies are conducted in several countries worldwide. They consist of employee surveys sent to a random sample of the organization's employees. The analysis of the results allows companies to see whether they have succeeded in creating a work environment that fosters employee engagement and performance. Hewitt places a strong emphasis on the notion of employee engagement, which it sees as critical to any strategy aimed at improving performance within an organization.

Employee engagement, as defined by Hewitt

Employee engagement is the measure of an employee's emotional and intellectual commitment to the organization for which he or she works.

Employees who are engaged adopt the following three behaviours:

- SAY: They speak positively about the organization;
- STAY: They demonstrate a strong desire to continue working for the organization;
- STRIVE: They exert extra effort to contribute to the organization's success.

6

FIND OUT MORE

Website for Top Employers Around the World:
http://was2.hewitt.com/bestemployers/pages/index.htm

Main website for Hewitt Associates:
www.hewittassociates.com

Canada's Top 100 Employers

For 10 years, Canada's Top 100 Employers has been holding an annual national competition to recognize the best places in Canada to work. The aim of this program is to identify the companies and organizations that are industry leaders in attracting and retaining employees.

Employers are evaluated by the editors of Canada's Top 100 Employers on the basis of eight criteria:

1. Physical workplace;
2. Work atmosphere and social climate;
3. Health, financial and family benefits;
4. Vacation and time off;
5. Employee communications;
6. Performance management;
7. Training and skills development;
8. Community involvement.

FIND OUT MORE

www.canadastop100.com/national/

Other initiatives

Quality Worklife Quality Healthcare Collaborative (QWQHC)
Healthy Healthcare Leadership Charter

The Quality Workplace Quality Healthcare collaborative (QWQHC) encourages the leaders of healthcare organizations and systems to demonstrate their commitment to improving the quality of work life in the healthcare field by signing the *Healthy Healthcare Leadership Charter*.

FIND OUT MORE

www.qwqhc.ca

Psychologically Healthy Workplace Awards and Best Practices Honors, American Psychological Association

The Psychologically Healthy Workplace Awards were conceived to recognize organizations' efforts to promote the health and well-being of their employees while improving their organization's success.

FIND OUT MORE

www.phwa.org/awards

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Themes

Chapter 1

SUPPORTING EMPLOYEE WELL-BEING AND PRODUCTIVE MANAGEMENT PRACTICES

Key Points

- The various management practices that promote and support the health and well-being of employees are not independent of each other. Therefore, strive for continuity and consistency across these practices.
- Consult employees on matters that affect their tasks, roles and responsibilities as well as the ways in which they carry out their work.
- Offer continuous and sufficient support to employees with respect to both the accomplishment of their tasks and personal issues, and encourage cooperation and support among employees.
- Adopt a work–life policy that encourages a balance between occupational and family demands.
- Develop, disseminate and oversee the application of policies concerning, in particular, civility, harassment and violence.
- Establish mechanisms for clear bilateral communication that contribute to transparency within the healthcare institution and provide opportunities for self-expression.

1 Introduction

A person's job has a huge impact on his or her psychological health, given that the former can be closely tied to an individual' self-esteem, social network and overall quality of life. As such, the culture and management practices within an organization can have a considerable influence on the well-being of its employees. In general, promoting health in the workplace results in notable benefits, including reduced levels of psychological distress, stress, anxiety, depression, burnout, and employee turnover, as well as improved quality of care[1, 2, 3].

When it comes to taking action, collective stress prevention initiatives should be a priority. Such initiatives, which seek to mitigate those factors that are detrimental to psychological well-being by bringing changes to the organization, are both effective and enduring. By comparison, while individual interventions (e.g. personal stress management) can also have beneficial effects, these are limited to the individual and tend to be short-lived.

2 Definitions

In this chapter, the term *psychological health* will be used interchangeably with *psychological well-being* to underscore the many dimensions that make up an individual and the importance of personal feelings and perceptions in the overall assessment of a person's state of mind.

From this perspective, psychological well-being can be defined more specifically as "a state of cognitive, emotional and behavioural stability that enables the person to be productive, maintain professional relationships, participate in activities his or her field and derive satisfaction from this." (Government of Quebec, Canada, 1985)[a]

When discussing psychological health in the workplace, stress is one of the issues most frequently raised. Indeed, stress-related problems have increased dramatically over the last three decades. Stress can be defined as a perceived imbalance between the demands of the environment and the individual's capacity to cope with them, given his or her personal resources[4].

3 Stress: a major factor in psychological health

Many researchers agree that stress is a negative experience caused by the interaction between the person and his or her environment, which results in psychological, physical and behavioural effects[5, 6]. However, stress can also be perceived as something positive when it is mild, temporary, and leads to improved performance and motivation at work. Indeed, this type of stress can promote the development of people's skills and self-confidence in mastering their jobs, as well as their identification with their work[7].

It is important, however, to make the distinction between acute and chronic stress. Acute stress allows the individual to adapt to a new, "high-stakes" situation. Once the stressor is no longer present, the feeling of stress disappears and is not generally harmful to the individual. Conversely, chronic stress is always deleterious to the individual, and it occurs when the perception of an imbalance between demands and resources is a daily phenomenon. A number of researchers have shown that chronic stress can have long-term consequences for the brain, specifically by altering memory and increasing the risk of illness.

3.1 What are the negative effects of stress?

The European Agency for Safety and Health at Work points out that, while the process of evaluating constraints and resources is a psychological one, the effects of stress are not solely psychological. Stress also affects a person's physical health, well-being and productivity. The effects of stress are many and can have both short- and long-term consequences for individuals. These consequences can be grouped into several categories:

- **Physical:** migraines, muscular tension, weight issues, digestive issues, cardiovascular problems, skin conditions, sleep disturbances;
- **Psychological:** depression, anxiety, memory loss, feelings of discouragement, irritability, job dissatisfaction;
- **Behavioural:** aggression, isolation, absenteeism, pathological gambling, interpersonal conflicts, drug or alcohol abuse.

a Translator's note: This is a loose translation of the original citation in French

3

Burnout is another outcome of a chronic state of occupational stress and is characterized by physical and mental exhaustion. Healthcare providers are a category of professionals that are at risk for this disorder. Although burnout is a common phenomenon, it is nonetheless uncommon for organizations to officially recognize it as a psychological health issue that necessitates treatment or requires the same level of workplace health and safety provisions as other illnesses, such as depression.

Burnout is characterized by a variety of symptoms:

> Emotional exhaustion or compassion fatigue: the feeling of affective or emotional saturation with respect to the sufferings of others;
> Disengagement in professional–patient relationships: negative or cynical attitudes and feelings toward patients, clients or users;
> Reduced sense of personal accomplishment at work: tendency to be overly self-critical.

3.2 Stress factors in the occupational environment

> **Factors relating to the job:**
  - Significant quantitative demands (work overload, time pressures);
  - Under-stimulation or underuse of skills (monotony, repetitiveness).
> **Factors relating to work organization:**
  - Poorly defined roles;
  - Lack of autonomy.
> **Factors relating to working relations:**
  - Lack of support from colleagues/superiors;
  - Non-participatory management (unjust management practices, authoritarian management);
  - Absence or under-recognition of work accomplished.
> **Factors relating to the physical or technical environment:**
  - Physical disturbances or discomfort in the work space (noise, heat);
  - Poorly designed work areas (lack of space, improper lighting).
> **Factors relating to the socio-economic environment of the organization:**
  - Uncertainty over the future of the organization;
  - Limited opportunities for learning or promotion.

In order of significance, the main sources of work stress are[8]:

1. Quantitative work overload;
2. Lack of recognition (appreciation from work associates);
3. Poor relations with one's superior;
4. Lack of involvement in decisions and insufficient communication of information.

It is important to note that stressors vary according to occupation and the nature of the tasks to be accomplished. For example, nursing staff tend to be stressed by ambiguous or conflicting roles and a shortage of personnel, whereas physicians are more likely to be stressed by patient expectations and the risk of being sued for malpractice[9]. Moreover, a study on nurses in China revealed that one of the leading stressors was having to confront illness and death on a daily basis[10].

4

Why should psychological health in the workplace be taken seriously?

The following is a list of findings demonstrating the costs associated with psychological health issues that are incurred by organizations and the healthcare system: While it remains difficult to quantify the social, family and human impacts of psychological health problems, certain statistics are rather revealing:

> The WHO predicts that by 2020, depression will become the second leading cause of disability across all ages and both sexes (after cardiovascular diseases). Currently, the Canadian Life and Health Insurance Association (CLHIA) estimates that depression costs $300 million annually in long-term disability payments;
> In 2000, close to one in three workers—or 41 million people—reported being affected by stress. In Europe, workplace stress is the second most frequently reported health problem and constitutes 50% of all long-term disability insurance claims[11];
> In France in 2000, the direct and indirect costs of stress were estimated to be between €830 million and €1.656 billion[11];
> In Europe, stress is the root cause of 50–60% of lost workdays, costing these countries at least €20 billion per year[12];
> The same observations have been made in the United States, where 54% of the 550 million lost work days per year are attributed to stress[13];
> In Switzerland, a study found that 58.1% of respondents felt their stress to be related to their work life, whereas only 4.5% cited their personal lives as the source of their stress[14].

More specifically, in the healthcare sector:

> 45% of healthcare providers in Canada reported that most days at work were “quite” or “extremely” stressful, compared with 31% of all Canadian workers[15];
> Among the professional groups reporting high levels of work stress were head nurses or nurse supervisors, medical laboratory technicians, medical specialists, general practitioners, family physicians, and registered nurses. Within these groups, the percentages of respondents who reported high work stress levels varied between 58% and 64%, with the exception of head nurses and nurse supervisors, 67% of whom reported high workplace stress levels.

Furthermore, the level of stress increases with the number of hours worked. Healthcare providers who worked 35 or more hours per week were much more likely to report high stress levels than were those who worked fewer than 35 hours per week. In addition, those whose schedule was other than a regular daytime shift were more likely to indicate high stress levels.

In Europe, as in the United States, there is growing interest in the issue of chronic stress in the workplace because of the extremely negative and costly impacts this reality can have on the operation of organizations[16, 17, 18].

What are the impacts on the organization?

In work settings where stress levels are high, the following can be observed:

> Increased absenteeism;
> Loss of motivation and creativity;
> Decreased productivity;
> Deterioration of the workplace atmosphere;
> Damage to corporate image.

When employees experience, among other things, elevated stress levels, burnout or psychological distress, the quality of care delivered may be compromised, and the rate of errors tends to increase.

5 Addressing the issues that influence psychological health

5.1 Organizational factors

The table below breaks down the main organizational factors that impact psychological health in the workplace. It is important to note that these factors are interconnected. Because they influence each other, any initiatives taken to promote psychological health in the workplace can ultimately impact several levels at once. These factors are described in greater detail in the sections that follow.

Work organization
Recognition
Workload
Roles and responsibilities
Employee involvement
Meaningfulness of work

Work relationships
Social support
Conflict resolution
Violence, harassment

Management style
Superiors' roles and leadership
Perception of organizational justice

Flexibility in the organization of work
Work–life balance
Return to work
Skills development

Organizational culture
Values
Communication and transparency

5.1.1 Work organization

We already know that aspects of a job that present a physical risk can affect employees' health—particularly those aspects that pertain to occupational health and safety (OHS). Nowadays, however, the risks to employees' psychosocial health are garnering more and more attention, and for good reason.

Recognition: a daily practice

Recognition is a major factor in terms of psychological health in the workplace. In fact, one study concluded that in Quebec, Canada, the risk of developing psychological distress among healthcare providers is 2.9 times higher if recognition within the workplace is weak[19]. Similarly, another study revealed that lack of recognition from one's colleagues and superiors is the second most important risk factor for psychological distress in the workplace[8].

As such, it seems critical that healthcare institutions develop and implement practices that promote daily recognition by immediate superiors and colleagues. These practices help foster acknowledgement of each person's contribution to the organization as well as identify training and professional development needs. Involving employees to a greater extent in the decision process, offering more opportunities to work in teams, and encouraging skills development are a few of the concrete measures that can be taken. In order to establish recognition practices that are appropriate to the work context and the employees, it is important to first clarify the various forms of recognition, as each is reinforced differently.

Figure 1 – The Four Forms of Workplace Recognition[20]

People >>>>>>> Work process >>>>>>> Results			
Existential recognition	Recognition of work practices	Recognition of dedication to work	Recognition of results

Existential recognition

Existential recognition is the basis for all other forms of recognition, because it focuses on the employee as a distinct individual. Through this type of recognition, individuals perceive that their right to express their opinions and influence decisions is acknowledged. This kind of recognition is usually expressed informally or privately. Here are a few examples:

> Decision latitude;
> Special arrangements for work schedule;
> Accessibility of management;
> Access to training programs.

Recognition of work practices

This type of recognition looks at how an employee performs a task as well as his or her behaviour, professional qualifications and skills. Among other factors acknowledged are innovation, creativity, and continued improvement of work methods. Here are some concrete examples of these practices:

> Peer feedback on professional skills;
> Celebration honouring the profession, or themed week (e.g. Nursing week);
> Public acknowledgement in front of peers;
> Recognition ceremony for the work team.

Recognition of dedication to work

Recognition of dedication to work relates to the contributions employees make, the risks they take to complete projects and the energy they expend, independent of results. It should be noted that the expression of recognition must be proportional to the effort invested by the employee. Here are some examples:

> Recognition for years of service;
> Commemoration of departures/retirements;
> Activities to celebrate instances of outstanding effort.

Recognition of results

This type of recognition bears directly on the results obtained and is therefore expressed once the task has been completed. The efficiency, usefulness and quality of work performed by employees can be acknowledged in a variety of ways:

> Celebration among colleagues to highlight the results;
> Announcing achievements in a meeting;
> Internal or external publication of results.

5

Project

Healthy Workplace, an Integrative Continuous Improvement Project **– University Geriatric Institute of Montreal – Montreal, Canada**

The latest revision to this recognition program included adding measures that acknowledge individuals, teams and departments for their efforts in the area of continuous quality improvement. Examples of these measures include:

- Interactive newspaper and *Interactif-Express;*
- Recognition evenings for years of service;
- Meetings with managers;
- Performance appreciation program (revised in 2008) whereby, by means of constructive discussion, the manager is, among other things, encouraged to acknowledge the employee's efforts;
- Celebration of teaching and authorship.

(See Project Description Nº 5)

Inspiring initiative

Recognition Toolkit **– The Scarborough Hospital (TSH) – Scarborough, Canada**

The *Recognition Toolkit* was designed to support the notion that consistent employee recognition boosts morale and promotes a positive work environment with productive employees. Approximately 100 resource binders were designed and produced, one for each TSH manager and director.

The toolkit included a four-step process describing the levels of recognition. Several resources were included in the kits to support each step:

- Identify behaviours: staff interview survey, a list of achievements and behaviours to recognize; chart to help the manager record the exact behaviours they want to recognize;
- Observe: identify opportunities: potluck proposal, certificates/awards, red-carpet greeting of new staff;
- Plan and describe behaviour and positive impact: code of conduct;
- Implement: recognition letter, recognition cards, gift cards (good job, congratulations, thank you).

Source: The Scarborough Hospital, 2009–2010 project inventory.

Moderate the workload

Specialists generally agree that their workload has increased considerably over the last 20 years[1]. When considering work overload, the first thing that comes to mind is the quantity of work. However, there are many dimensions to the experience of work overload: quantitative, a large volume of work to complete in a short period of time; qualitative, a lack of skills needed to perform the tasks required; and emotional, having to manage one's own emotions while responding to the emotional needs of others[21]. This latter issue is often overlooked in studies exploring work overload. Nonetheless, its existence is very real, especially in the field of healthcare and social services. Healthcare providers are frequently exposed to situations that are very emotionally demanding. One need only think of the nurse who cares for dying people every day, or the educator who works with youths in crisis. Among healthcare workers, high workplace demands were found to correlate with absenteeism in a population of Finnish doctors[22], and poor psychological health in Spanish employees[23]. A study conducted in 2000 by the European Foundation for the Improvement of Living and Working Conditions revealed that 56% of European workers reported working at a frenzied pace, and 60% reported having very tight deadlines.

With respect to work-related emotional overload, or compassion fatigue, a phenomenon known as *vicarious traumatization* explains how a person can experience psychological trauma without having been a direct victim of a traumatic event simply as a result of witnessing the accounts of a person who has. People who work in the helping professions can develop symptoms that resemble those of trauma victims[24]. For example, a healthcare provider can take on the anger and distress that victims carry. Vicarious traumatization can affect one's perception of self and the world (e.g. loss of sense of safety and trust, despair, disillusionment, etc.). On the work front, this can cause an individual to have difficulty separating the personal from the professional, to become less effective on the job, or to lose a sense of meaning in, or enthusiasm for, their work[25].

The Karasek model[7] is often cited in discussions of work overload. This model is based on a notion of equilibrium between two dimensions:

> The "psychological demands" associated with the performance of tasks in terms of complexity, quantity, time constraints, etc.;
> "Decision latitude," meaning the exercise of control in how tasks are performed and the opportunity to use and develop one's skills.

		Psychological demands	
		Low	High
Decision latitude	Low	*Passive work*	*High-strain work*
	High	*Low-strain work*	*Active work*

A work situation characterized by a combination of high psychological demands and low decision latitude increases the risks for developing psychological and physical problems[7]. A study of healthcare providers conducted in Quebec, Canada, found that high psychological demands in the workplace were associated with high psychological health risks[19]. However, the presence of workplace social support from colleagues and superiors moderated this relationship. Specifically, a situation combining high psychological demands and low decision latitude—"high-strain work" or work overload—is better tolerated if the person is supported in his or her professional environment.

Moderating the workload benefits employees in a number of ways, including boosting their well-being and improving their effectiveness and productivity[1]. It has also been observed that a reasonable workload and a pace of production that is appropriate to human capacities are associated with positive economic performance. Establishing stable work teams is a useful strategy for reducing workload while at the same time promoting team spirit[26]. Indeed, multidisciplinary care teams are more and more common in specialized and long-term care facilities. These teams offer substantial benefits, including[9]:

> Efficient care delivery that does not compromise quality;
> Time savings, as a team can execute tasks in parallel that a single person would otherwise have to complete sequentially;
> Fostering innovation through the exchange of ideas;
> Integration and assimilation of information as a team.

TAKE ACTION

To achieve a more balanced workload, some concrete actions the healthcare institution can take include:

> **Assessing the current workload;**
> **Encouraging employees to get involved in defining their own workload;**
> **Minimizing work interruptions;**
> **Prioritizing value-added tasks;**
> **Providing opportunities to share and reflect on situations of high emotional demand.**

5

Projects

***Mental Workload Management Model* – Etelä-Savo Hospital District – Mikkeli, Finland**
This hospital's senior management established a work team to support the implementation of a large-scale workload management project in 2008. The work team established a number of regulations concerning employee workload and working conditions. The project brought several positive outcomes, including a reduction in short-term absences, sick leaves and workplace accidents. Moreover, a survey on the work climate revealed that employees experienced an improvement in working conditions in 2008 compared with 2007.
(See Project Description Nº 6)

***On the Other Side* – Hospital of Santa Maria Nuova of Reggio Emilia – Reggio Emilia, Italy**
The primary goals of this project were to improve relations between the administrative and technical staff of the mammography department and the patients accessing this service, as well as reduce the prevalence of burnout among staff. The professionals therefore needed support to acquire and develop new skills, particularly in an environment of high emotional and psychological demands.
(See Project Description Nº 7)

***Establishing Stable Care Teams and Regulating Operational Systems* – Sacré-Cœur Hospital of Montreal – Montreal, Canada**
This project arose out of a partnership with CRISO (an organizational health research and intervention centre) and with the help of a CHSRF (Canadian Health Services Research Foundation) grant. The project was aimed at improving the hospital's working environment and supporting the care units, the rationale being that if work teams are stable and the environment conducive to work, the care delivered can only improve.
(See Project Description Nº 8)

Clearly define roles and responsibilities

Problems arise when there is ambiguity or conflict surrounding roles and responsibilities. Role ambiguity consists of an uncertainty on the part of employees as to what is expected of them in terms of the tasks they are supposed to accomplish and the responsibilities under their purview. Role conflict occurs when employees find themselves in a situation wherein what they are expected to do is incompatible or contradicts with the roles and responsibilities of their colleagues or supervisors. A role conflict can also occur when employees' values, beliefs and goals clash with their superiors' expectations of them[27].

Role ambiguity and role conflict are linked to absenteeism, poor job performance,[28] employee job dissatisfaction and feelings of anxiety[29].

It is interesting to note the link that can exist between certain organizational practices and the compounding and mutually beneficial effects they can have. For instance, by having employees become more involved in organizational and decision processes, they are given access to more information about the organization. This then enables them to exercise greater control over their work. Such an action demonstrates the employer's recognition of the employees' contribution to the institution. It also fosters discussion and interaction between the organization's members, which has the added effect of strengthening social bonds. Social support is indeed a significant factor in promoting psychological health in the workplace and will be a topic of further discussion in a subsequent section.

TAKE ACTION

To avoid creating situations of role conflict or ambiguity, the healthcare institution can:

- **Clarify the expectations and objectives for each occupation and modify job descriptions as needed;**
- **Clarify the roles of all employees working on a team and ensure that the contribution of each individual is respected;**
- **Reassign tasks that fall outside the employee's role;**
- **Develop a mentorship program for new employees.**

Project

Health Professions Today: Clarifying Professionals' Roles **– Local Health Unit of Bologna – Bologna, Italy**

The aim of this project was to reduce role ambiguity by reconciling employees' perceptions of their skills with the actual skills required or expected by the institution for their respective roles. Through group discussions, accounts of problematic work experiences, and personal descriptions of skills, this project led the employees to become more aware of their own skills as well as those required by the institution.

(See Project Description Nº 9)

Getting employees involved: a key factor in workplace psychological health

As mentioned above in reference to the Karasek model, the degree of employee participation in an organization's decision making process is a significant factor in the psychological well-being of employees. In fact, some authors claim that insufficient employee involvement is manifestly linked to high psychological tension, alcohol abuse, depression, poor physical health, low self-esteem and low job satisfaction[7]. Many studies have also demonstrated the negative impact of low decision latitude on cardiovascular disease and on psychological problems like depression and burnout[19, 26].

A study conducted in 2005 reported that 42.9% of adult residents of Montreal, Canada, experience low decision latitude at work[30]. According to a study of 14 long-term care facilities in Quebec, Canada, 86% of respondents reported low decision latitude, and a considerable number of these respondents also showed signs of high levels of psychological distress[26].

Conversely, autonomy and participation in decision making signals to employees their importance within the organization and enables them to assert themselves in the workplace, a factor that is essential to the overall health and effectiveness of the organization[1]. Four strategies can be used to foster employee autonomy by allowing them to:

- Demonstrate their creativity and exercise their skills;
- Have a say in their tasks;
- Make independent decisions;
- Take part in the definition of their working conditions.

Two elements are key to employee involvement in decisions: employee consultation and openness of managers to employee suggestions[1].

Involvement in the decision making process can take place at two levels: organizational and individual. Participation at the organizational level allows employees to influence the direction and strategies of the organization, whereas participation at the individual level relates to decisions that have a direct impact on the day-to-day work of individuals. Both of these features help reduce employees' psychological tension while at the same time increasing their job satisfaction and self-esteem[27].

5

TAKE ACTION

In order to foster employee participation in the decision making process, the healthcare institution would benefit from:

- **Giving employees more leeway in the way they carry out their work;**
- **Encouraging employee involvement in the decision making process by welcoming their suggestions and comments;**
- **Encouraging employees to participate in the definition of their job descriptions;**
- **Maximizing work team autonomy.**

Inspiring initiative

***Participatory Work Organization Initiative* – CLSC-CHSLD Haute-Ville-des-Rivières – Quebec city, Canada**

In collaboration with the RIPOST team (Research into psychological, organizational and social effects of work), members of the workplace health committee at this Montreal long-term care facility were mandated implement a program aimed at preventing and reducing work-related psychological health problems, for which absenteeism is one indicator. This initiative was carried out using a participatory approach involving employees and managers on a parity committee to search for solutions to situations that present organizational risk factors for the psychological health of employees.

Source: Association paritaire pour la santé et la sécurité du travail du secteur affaires sociales (ASSTSAS) [Parity association for workplace health and safety in the social services sector] Participative work organization initiative www.asstsas.qc.ca/dossiers-thematiques/sante-psychologique/pratiques-ingenieuses/demarche-participative-sur-lorganisation-du-travail.html *(in French only)*

Provide the conditions for meaningful work

A sense of meaning in one's job can be defined as the value the work has to the individual, what he or she seeks to get out of the work, and a balance between the individual, his or her expectations, his or her values and the tasks that are carried out in the workplace on a daily basis[31]. Several factors contribute to making one's job meaningful. An individual's enjoyment of the tasks he or she carries out and the conditions in which they are executed are one example. According to studies conducted in a range of work settings in Quebec, Canada, since 1997, five factors appear to determine whether a job is meaningful[31]:

- Social usefulness of the work;
- Moral integrity of the work;
- Opportunities to learn and develop;
- Autonomy;
- Quality of professional relationships.

Individuals who take pleasure in their work and have opportunities to learn and develop perceive that they have autonomy in their job, enjoy positive working relations, and are highly likely to present with a state of psychological well-being in the workplace[31].

TAKE ACTION

To create the conditions conducive to meaningful work, the healthcare institution can:

- **Offer every employee opportunities to learn and develop;**
- **Give employees a degree of flexibility in how they structure their work;**
- **Allow employees to exercise their judgment and shape their working environment;**
- **Foster positive working relations;**
- **Support employee autonomy in tasks pertaining to their respective skill sets.**

Projects

Weeks for Joy of Living **– Central Finland Health Care District – Finland**

The institution sought to ramp up its focus on health promotion and empowerment among employees. This project offered hospital employees the opportunity to use their skills, abilities and knowledge for the joy of others. Different units in the hospital were invited to take action to enhance collective well-being: e.g. photos, dancing lessons, sports, theatre, concerts, etc.

(See Project Description Nº 10)

Improving Employee Attraction, Involvement and Retention Practices **– Rehabilitation Centre Marie Enfant (CRME) – Montreal, Canada**

The CRME launched a project to improve its practices with respect to attracting, motivating and retaining employees. As a first step, this involved establishing a precise picture of what would enable the CRME to become an "employer-of-choice"; in other words, identifying what employees consider important and appealing in a work environment.

(See Project Description Nº 11)

5.1.2 Work relationships

The interpersonal aspect of work has considerable influence on whether or not employees enjoy their job, and, by extension, considerable impact on their psychological well-being in the workplace. As such, positive relationships with colleagues and superiors bolster psychological health, whereas tension or even conflict in work relationships can create adverse situations of greater or lesser severity, depending on the nature of the problem.

Social support: a buffer to stress

As previously mentioned, social support is very important in promoting psychological health in the workplace. In fact, it appears that social support alleviates the deleterious effects stress has on individuals, and does so by influencing peoples' perceptions of stressors and by encouraging the development of strategies to cope with the stress[32].

A study of hospital employees in Spain showed that those who had healthy marital relationships had fewer psychosocial health problems, possibly due to a higher degree of family support[23]. Weak social support in the workplace was associated with poorer psychological health and limited social roles among healthcare providers[23].

A study of Finnish physicians revealed that a lack of social support was more strongly associated with absenteeism than high work demands or low decision latitude[22]. In Quebec, Canada, the risk of developing psychological distress among healthcare providers was 1.35 times higher if workplace social support was low[19].

Organizations can provide two types of support: instrumental support, pertaining to the completion of tasks; and emotional support, which is much more centred on the individual[1]. These two types of support seem to protect the individual by either preventing or minimizing the severity of an episode of psychological distress[33]. Instrumental support can, for example, facilitate employees' ability to carry out their daily tasks through discussion of problems encountered or strategies to adopt. Emotional support from peers provides backing and reassurance as well as a feeling of belonging to a group, all of which creates a potent buffer. In fact, peer support is all the more important because these individuals share the same job and experience the same challenges[34].

Having positive relations with, and support from, one's supervisor remains an important determinant for job satisfaction. This subject will be more thoroughly discussed in the section on management styles.

5

TAKE ACTION

To promote social support in the workplace, the healthcare institution can:

- **Promote teamwork and encourage support and cooperation;**
- **Encourage managers to be attentive to employees and carry out recognition practices;**
- **Provide team-building activities;**
- **Form support networks among colleagues;**
- **Organize sports or social activities for staff members.**

Project

Support Group **– CSSS du Sud-Ouest-Verdun, Yvon Brunet Residence – Montreal, Canada**

This project constitutes a preventive psychological health initiative for the workplace. A group of employees, chosen by their peers for their superior listening skills, offer informal and confidential support to their colleagues. Having received training on support and listening practices, these individuals act as agents of preventive healthcare in their work setting.

(See Project Description Nº 12)

Give your staff the tools to prevent and manage conflict

When it comes to conflict management, prevention and proactive management are key ingredients for success. In fact, the negative consequences of unresolved conflicts are many: stress, frustration, tense relations, absenteeism, disability claims, and an increased number of complaints of psychological harassment. Prevention and resolution of workplace conflict are thus two essential conditions for establishing healthy working relations and creating a collaborative environment.

To facilitate the resolution of conflicts and disagreements and prevent the work atmosphere from becoming poisoned, it is imperative to adequately equip managers and employees to recognize the warning signs of a conflict as quickly as possible. Managers are an important part of the solution in such cases, owing to their supervisory role. Of course, they must receive support in this process should they encounter difficulties in the resolution of conflicts. Training in conflict identification and management would therefore be a worthwhile investment for healthcare institutions interested in adopting a proactive approach.

There is also a positive side to conflict, in that it constitutes an opportunity for growth when it can be resolved in an atmosphere of respect for others, their opinions and their differences. For example, when a team has gone through a number of conflicts that have been resolved in a respectful manner and has emerged from them with positive lessons learned, that team will be better equipped to handle similar situations in the future. Moreover, a conflict can often trigger a review of outdated operating procedures or inefficient processes and thus be a catalyst for creativity and innovation. Finally, addressing the conflict directly allows differences of ideas and opinions to be aired in a healthy manner. By questioning certain aspects of working procedures, tasks or resource allocations openly and honestly, avenues for solutions emerge, allowing individuals, the team, and the organization to move forward[35].

TAKE ACTION

To manage conflicts effectively, the healthcare institution can:

- **Manage conflicts by encouraging the sharing of, and openness to, ideas;**
- **Conduct communication and team-building activities;**
- **Observe and analyze the work atmosphere and react promptly;**
- **Establish mechanisms that promote conflict prevention and management;**
- **Offer training in conflict management as needed.**

Countering harassment and violence

The lines between the notions of violence and harassment in the workplace are often blurred, and the two terms are often used interchangeably to describe the same reality. Reference is often made, however, to different types of harassment and/or violence: discriminatory, sexual, psychological and criminal. Despite the fact that such conduct is, by its very nature, recurrent, a single serious incident can be enough to be considered harassment.

Violence in the workplace generally consists of threats, insults, physical or psychological assaults against a person in the context of the performance of his or her job, which jeopardizes the person's health, safety or well-being[36].

Violence can manifest in the following forms[37]:

- Incivility: disrespect for others as expressed through communication, behaviour, etc.;
- Verbal assaults: threats, insults, etc.;
- Violent acts: destruction or damage to property, etc.;
- Physical assaults: pushing or shoving, hitting, inflicting injuries, etc.

Incidents of violence arise from various sources, both within and outside an organization. Internal sources include not only superiors, but subordinates and colleagues as well.

Workplace violence is considered external when the aggressor is not part of the organization itself. People working in the healthcare field are particularly at risk, because they are in contact with a clientele that can sometimes exhibit violent or aggressive behaviours.

According to a study conducted in Ireland, 29% of injuries caused by violence involved someone in healthcare services. In Sweden, one out of every two cases of violence involves a healthcare provider (primarily in psychiatric facilities or social services settings). In France, 8% of women and 7% of men report having been the victim of psychological harassment or bullying in the workplace. France's workplace violence rates are within the European average of 5%[38].

In addition, a relationship exists between stress, harassment and violence. Indeed, these three phenomena are not independent of one another. For instance, an incident of harassment will provoke a state of stress in the victim and his or her environment, because the effects of violence are not restricted to the victim but extend to the victim's colleagues, family members, and witnesses to the incident. Furthermore, a state of high work stress can fuel harassment and violence[37].

Harassment can lead the victim to suffer a loss of self-confidence, anxiety, and even depression. If the effects of violence are ignored by victims, their psychological health problems can degenerate and notably lead to dependency issues such as alcoholism or drug addiction. In a worst-case scenario, burying these problems can lead to workplace suicide[21].

Healthcare and social service providers are exposed to violent and thus potentially traumatizing events. Post-traumatic stress disorder is a severe anxiety problem that manifests following a traumatic event. It is characterized by a psychological reaction to a situation in which the physical and/or psychological safety of the patient and/or his environment was threatened and/or violated. This problem can have significant consequences for a person's ability to function and can pervade every sphere of his or her life, including personal, professional, family and social. The length of time it takes to return to a healthy state depends on the quality of care the victim receives. Psychological support often prevents the occurrence of complications or the persistence of symptoms related to a violent incident[36]. The topic of violence is also discussed in Chapter 2, *Improving Employees' Physical Environment and Making It Safer*.

5

Projects

Fostering a Respectful Workplace and Preventing Violence **– Chatham-Kent Health Alliance – Ontario, Canada**

The aim of this project was to promote a healthy and safe work environment. The objective was to prevent any incident of intimidation, violence, harassment or discrimination by providing employees and managers with the tools to identify, report and/or manage any instance of workplace violence.

(See Project Description Nº 13)

The Clinico-Legal Intervention Committee (CLIC) **– The West Montreal Readaptation Centre, the Lisette-Dupras Rehabilitation Centre and the Gabrielle-Major Rehabilitation Centre for Intellectual Disabilities – Montreal, Canada**

The CLIC's mission is to guide and support clinical teams and their managers with respect to difficult clients who present an elevated risk to themselves, others and/or the establishment. The CLIC intervention complements the Centres' risk management and clinical practice improvement systems. This project yielded positive results, including, among other things, the reduction of acts of aggression against users referred to the CLIC and the reduction in the number of emergency calls to police by users referred to the CLIC.

(See Project Description Nº 14)

TAKE ACTION

To prevent and/or effectively manage incidents of violence within the healthcare institution, you can:

- **Launch awareness and prevention campaigns;**
- **Evaluate, with the help of employees, the risks of occurrence of such incidents;**
- **Train employees in early identification of aggressive behaviours and the systematic analysis of assault (notably to identify the potential for external violence);**
- **Establish, communicate, and enforce the application of policies on civility, harassment, and violence.**

Inspiring initiatives

Policy on the Prevention and Management of User Violence against Personnel **– Montreal Youth Centre – University Institute – Montreal, Canada**

Concerned about supporting staff and clients who were victims of potentially traumatic events, the Montreal Youth Centre established a post-traumatic intervention team in 1999. The launch of this team's activities was marked by the adoption of an initial post-traumatic intervention protocol by the steering committee. The current policy is a revised version of this protocol. It asserts the centre's concern for and stance on assuring the preservation of the psychological and physical integrity of persons affected by such events.

Source: Montreal Youth Centre – University Institute: Management manual – Policy on the prevention and management of user violence against personnel. Adopted by the board of directors April 23, 2002 and revised March 12, 2007.

Becoming Bully-Free at Work: Information, Inspiration and Implementation **– Ontario Hospital Association – Ontario, Canada**

This one-day workshop addressed topics pertaining to workplace intimidation or bullying. It also provided employees with practical strategies to reduce or mitigate the negative effects of bullying, in order to build a culture of respect as an integral part of a healthy work environment.

Source: Ontario Hospital Association, www.oha.com/Education

SUGGESTED WEBSITES

Victim help associations

"Harcèlement Moral Stop" [No more psychological harassment]: association for the fight against workplace bullying (HMS, France)
www.hmstop.com (in French only)

Association contre le harcèlement professionnel (ACHP, France) [Association against workplace bullying]

5.1.3 Management style

There is no doubt that the management style of supervisors and managers has a major impact on the psychological well-being of their staff. The first part of this section discusses the role of supervisors and the effects of their leadership style, and the second part deals with the perception of organizational justice. It is a fact that an employee's perceptions of justice within the organization as a whole are often based on the signals they observe coming from their managers, who, for the employee, generally represent senior management.

The role of managers and the positive impact of (constructive) leadership

As noted in the section on social support, the role of the superior is a key organizational component that can influence employee psychological health. According to the INSPQ (Quebec public health institute in Canada), supportive supervisors are those who are concerned for their employees' well-being and attentive to their needs, hold regular meetings, and establish committees in which people work together on projects or find solutions to operational problems. This style of manager promotes productivity by giving employees the time they need to complete their tasks as well as the necessary tools and resources to do so[39]. Employees who feel supported by their superiors are less likely to experience psychological distress.

Leadership that is based on the sharing of a common vision and values and is centred on the training, consultation, support and well-being of employees unequivocally represents a management style that fosters psychological health in the workplace[40]. Good leaders also demonstrate openness to suggestions from their team members and possess a certain knack for communication[41]. Conversely, an authoritarian leadership style that does not foster employee participation in decisions concerning the execution of their jobs may contribute to an increase in the level of psychological tension in workers[42] as well as the emergence of workplace tensions and conflicts.

TAKE ACTION

- **Ensure that upper and middle managers take a more in-depth look at questions pertaining to organizational culture and quality of work life;**
- **Train and encourage managers to adopt a positive leadership style.**

In particular, good manager must:

- **Hold regular team meetings;**
- **Implement mechanisms to evaluate and follow up on employee suggestions and requests;**
- **Manage conflicts promptly and serve as a mediator[39].**

5

Inspiring initiative

Positive Psychology at Work: Towards Flourishing Workplaces **– European Agency for Safety and Health at Work – Finland**

Training offered in Finland by the European Agency for Safety and Health at Work. Key concepts include positive work and organizational psychology, with a special focus on leadership, innovation, and staff engagement in teams and organizations. The program encompasses theoretical relationships and the associations between these concepts, as well as methodological issues and effective and innovative intervention strategies.

Source: www.osha.europa.eu/en

The importance of perceived organizational justice

The perception of organizational justice is yet another determinant of employee psychological health. Indeed, the sense of justice is closely related to the notion of trust, which is vital to the existence of a positive employer–employee relationship. Moreover, perceptions of injustice compound the effects of stress.

TAKE ACTION

In order to reinforce the perception of organizational justice, it is important to:

- **Ensure that the demands are realistic, the effort required is reasonable, and the rewards are equitable;**
- **Be transparent about procedures and rules used in making decisions;**
- **Take care to maintain a relationship of trust with one's staff.**

There are three types of organizational justice: distributive, procedural, and interactional. Distributive justice concerns the perception employees have about the correlation between their contribution to the organization and what they receive from it in return. Procedural justice refers to the sense of fairness surrounding the rules and procedures used to make decisions within the organization. Lastly, interactional justice relates to perceptions about the quality of interpersonal treatment received. A favourable perception of these three types of justice promotes an affective commitment on the part of the employee toward the organization[43].

Siegrist (1996) proposed a model that aptly illustrates a situation that can lead to a perception of organizational injustice. Indeed, Siegrist's effort–reward imbalance model (Siegrist, 1996) stipulates that a work situation characterized by high efforts with low rewards engenders emotionally and physiologically pathological responses. A "high" effort level can be extrinsic or intrinsic in nature. Extrinsic effort pertains to the psychological and physical demands of the job, whereas high intrinsic effort, or overinvestment, refers to attitudes and motivations related to an inner need to further oneself or obtain approval, or an innate desire for the sense of gratification that comes with overcoming challenges or gaining control over a threatening situation[44]. "Low" rewards can be divided into three areas: monetary (inadequate pay); social (lack of recognition or respect from colleagues or managers) and organizational (job insecurity, lack of promotion prospects)[45, 46]. As such, the concept of organizational justice is tied to the perception employees have about the balance between the efforts made and rewards received for these efforts.

5.1.4 Flexibility in the organization of work

Having flexibility in the organization of one's work can mitigate the negative effects that certain working conditions can have on employees' health, as well as their family and social life. This is particularly true in the health and social services context, wherein services need to be provided on a 24/7 basis. For many employees, these requirements call for irregular schedules and difficulties balancing personal and work life, impacting the individual's health. Many studies have demonstrated the link between irregular work schedules and the presentation of psychological distress[33], sleep disorders, and excessive behaviours such as the disproportionate consumption of food, cigarettes, drugs or alcohol, all of which can lead to absenteeism and an increased rate of workplace accidents[47]. According to a German study, "a positive correlation exists between excessively long working hours and mental and physical fatigue, and gastrointestinal and heart disorders."[48]

It is nonetheless possible to mitigate these problems by increasing the flexibility with which employees can organize their work. Specifically, this can be done by promoting a work–life balance, offering adequate support to those returning to work after a leave of absence taken for psychological reasons, and by encouraging the development and acquisition of skills.

Promote a work–life balance

Tension between work and personal life, or difficulty in maintaining a balance between the two, can, over time, have negative consequences for psychological health. A conflict between work and personal life occurs when the demands of work and family are incompatible with each other, therefore making it difficult to fulfill one role without compromising the other[49].

One study found a significant difference in job satisfaction between employees who had difficulty balancing their professional obligations with their personal lives and those who did not[50]. Specifically, only 27% of individuals who had considerable work–life conflict were satisfied with their jobs, whereas 80% of employees who did not have work–life conflict reported being satisfied with their jobs. According to a meta-analysis conducted by several authors, there is a high correlation between cases of work – family conflict and depression[51].

TAKE ACTION

To successfully promote a work–life balance, the healthcare institution can:

- **Adopt a work–life balance policy;**
- **Offer flexible work schedules;**
- **Sensitize managers to the importance of having a conciliatory attitude (e.g. listen to and be understanding toward employees);**
- **Find a way to equitably manage requests for personal leaves.**

At the organizational level, work–life conflicts have been associated with inferior job performance, increased absenteeism, high employee turnover and lack of motivation[52]. Employees who experience work–life conflicts are also less engaged, report higher levels of stress and give more serious consideration to quitting their jobs[53]. According to the National Work – Life Conflict Study conducted by Health Canada in 2001, employees whose work strongly interferes with their family lives are seven times more likely to state that they are considering leaving their current organization because they want to devote more time to their family, and that their work expectations are unrealistic[54].

Lastly, the more employees feel that their professional demands conflict with their family obligations, the lower they perceive their performance at work[55].

5

Project

***Kailo Workplace Wellness Program* – Halton Healthcare Services – Ontario, Canada**

This program was initially focused on psychosocial issues, such as stress management, life satisfaction and work–life balance. All programming and services were therefore oriented toward having fun at work. Beginning in 2008, the Kailo project further evolved and expanded to offer new programs and services, such as training on topics in workplace health and well-being.

(See Project Description Nº 4)

Facilitate the return to work

The return to work from a leave taken for psychological health reasons is often accompanied by feelings of vulnerability and a fear of relapse. Regaining confidence in one's skills and in one's capacity to function well in one's job is a gradual process. As such, tangible support from colleagues and superiors is a determining factor in rebuilding health and continuing in one's job[56].

It is important to note that obstacles to work reintegration are not solely due to factors inherent to the individual; organizational factors play a prominent role as well. According to one study of people who had reintegrated into the workforce following burnout, the successful transition between a leave of absence and the resumption of one's job was dependent on changing the organizational conditions that contributed to the work leave in the first place[57].

It is therefore critical to identify the factors involved in any given leave of absence. This process enables organizations to a draw a relationship between employees, the characteristics of their illness and the events that precipitate the work leave. It also provides employers with a clear picture of the various occupational factors that can tend to erode people's health[56].

Results of one study of work reintegration showed that conflicts with colleagues (especially with immediate supervisors), negative performance evaluations by supervisors, and lack of recognition of the employee's efforts on the job are the occupational factors most frequently cited by employees when explaining what contributed to their leave of absence[56]. These findings provide insight into the main factors that healthcare institutions should consider in promoting employees' psychological health and assuring the conditions necessary for a positive and constructive return to work. Furthermore, study participants who reported positive changes to their jobs following their return were significantly more likely to conclude that their psychological problems were resolved. As such, improving the work conditions that contributed to the illness and leave of absence led to successful work reintegration, psychological health and job maintenance[56].

TAKE ACTION

- **Prior to the return to work, the manager should meet with the person on leave in order to assess needs;**
- **Try as much as possible to adapt to the employee's needs;**
- **Reorganize the employee's work as needed;**
- **Offer the option of a gradual return to work, monitored by an industrial relations consultant;**
- **Prepare colleagues to welcome the person back from leave.**

SUGGESTED WEBSITE

Great-West Life Centre for Mental Health in the Workplace – Return to Work
www.gwlcentreformentalhealth.com

Encourage skills acquisition and development

Uncertainties about opportunities for career advancement or skills development are factors that can threaten employees' psychological health. Major organizational changes are another source of worry often cited as impacting the psychological health of employees. A longitudinal study of hospital employees who underwent a hospital restructuring indeed found an increase in depression, anxiety, burnout and job insecurity among the staff[58]. In another study, it was found that hospital downsizing and restructuring were associated with job dissatisfaction and poorer psychological health[59]. When it comes to change, the people affected have concerns about the experience of the change itself—in other words, in their capacity to handle the change, the support that will be available to them during the change, and the understanding of their superiors. One of the priorities for management with respect to these concerns is to facilitate the transfer of new knowledge and skills through training, guidance and the provision of a period of adjustment to the new skills. (See Part 2, Chapter 1, *A Process for Implementing Healthy Workplaces,* p. 20)

It is very important for staff to be given opportunities for professional development in their jobs. Employees are likely to view such opportunities as evidence that their employers recognize their contribution. The new skills targeted can range from the optimization of work processes to the acquisition of interpersonal skills in order to promote teamwork. The organization might also want to check with management staff to determine whether they have the skills they need to adequately perform the duties and responsibilities associated with their role. Training can then be offered that targets specific management skills.

Conversely, situations wherein employees do not have the opportunity to use their skills and qualifications in their job, or where the physical and mental tasks are highly routine, can lead to boredom and a decrease in motivation and job satisfaction, as well as an increase in absenteeism rates[7, 60].

TAKE ACTION

- **Establish a professional development program for staff;**
- **Provide opportunities for cross-disciplinary training and skills development;**
- **Ensure that employees have the opportunity to use their skills and qualifications in their daily tasks;**
- **Evaluate and improve orientation and mentorship programs;**
- **Establish a management training program.**

Project

***Healthy Workplace – An Integrative Continuous Improvement Project* – University Geriatric Institute of Montreal – Montreal, Canada**

Among other things, this project promoted skills development by offering training and mentorship to managers in order to broaden their expertise in team management. Training was also offered to staff on risk management, handling emergency situations, safety and individual patient needs. A succession/mentorship program for managers also enabled selected people to perfect their management skills.

(See Project Description Nº 5)

5

Inspiring initiative

***My Life, My Choices, My Career at the MUHC* – McGill University Hospital Centre – Montreal, Canada**

This education support program is offered to nurses, nursing assistants, respiratory therapists and perfusionists. For those who are interested, the program offers access to scholarships, reimbursement for tuition fees, as well as the opportunity to participate in a college–university co-operative education program.

Source: *Destination Health* (April 2009). Workplace Health Promotion Programs: Organizational Practices and Quality of Life at Work. Montreal Network of Health Promoting Hospitals and CSSSs. Vol. 1, nº 3. www.santemontreal.qc.ca

5.1.5 Organizational culture

To demonstrate that an organization is mindful of the psychological welfare of its workers, a number of practices can be initiated within the organizational culture. To begin with, the promotion of psychological health must be an integral part of the organization's values and orientations. Management practices must then comply with workplace health promotion, and a resource plan to support these practices must be provided[53].

Promoting psychological health through organizational values

It is important to stress the importance of organizational culture in the promotion of health in the workplace. Indeed, the culture reflects the efforts made by the organization in this regard. For instance, even if an individual learns and masters various stress-management techniques, if the organizational culture runs counter to these efforts, the benefits of these techniques for the employee will be limited or non-existent.

Clearly, in order to establish and support a culture that promotes the psychological health of its staff, steps must be taken to inform and involve all parties concerned, including senior management, managers, unions, employees, and human resources. A culture based on common values like honesty, integrity, respect for others, and mutual trust greatly bolsters the psychological well-being of employees.

TAKE ACTION

- **Ensure that the mission, vision and value statements express the importance placed on the psychological health of employees;**
- **Supply the resources necessary to promote health in the workplace;**
- **Adopt a policy on respect for people and diversity;**
- **Set an example and show proof of the commitment of senior management.**

Conversely, an organizational culture rooted in competition, short-term results, or a worship of excellence can undermine and impede workplace social support, which is a vital factor in maintaining psychological health in the workplace. Moreover, an organizational culture that condones violent behaviour, inequity or injustice makes itself vulnerable to psychological health problems[21]. Such a situation is worrying, because disrespectful attitudes can be detrimental to the psychological health of the individual concerned, poison the work atmosphere, create conflicts, slow productivity and weaken the services offered[1].

Inspiring initiative

European Network for Workplace Health Promotion (ENWHP)

Through a European campaign entitled "Work in tune with life: Move Europe," the European Network for Workplace Health Promotion (ENWHP) launched an initiative to help promote psychological health in the workplace. The campaign was co-funded by the European Commission under the 2003–2008 Public Health Programme. Under the leadership of the BKK Bundesverband (National Contact Office in Germany), the aim of the 8th ENWHP pan-European was to:

- Increase the awareness of companies and the general public about the need for and benefits of psychological health promotion at work;
- Prompt companies to take part in the campaign and convince them that investments in workplace psychological health promotion initiatives are worthwhile;
- Design practical measures and models for promoting psychological health in workplace settings and encourage an exchange of experience in this field.

Source: www.enwhp.org

The importance of communication and transparency

Open communication and the free exchange of information between and among all members and all levels of an organization are part and parcel of an organizational culture that is dedicated to the well-being of its staff. These two practices positively influence decision latitude and recognition of the importance of the employee to the organization.

The circulation of information must take place at both organizational and individual levels. Organizational information informs employees about the institution's general orientations and functioning, whereas information transferred between individuals enlightens employees about issues that affect their jobs directly or enable them to perform their tasks in the best way possible[27].

TAKE ACTION

- **Determine the need for team meetings;**
- **Provide training to managers on using team meetings to circulate information;**
- **Establish a clear information dissemination policy;**
- **Implement mechanisms for clear and functional bilateral communication.**

Project

***On the Road to Excellence: Adaptation of the Magnet Hospital Model* – Montreal Shriners Hospital for Children – Montreal, Canada**

A number of interesting initiatives were developed to promote communication at the hospital. Here are some examples:

- Monthly general meetings;
- Internal and external newsletters;
- Internal sharing of expertise via presentations given by staff;
- Annual open houses in each department;
- Grouping of single- and multidisciplinary experts within the Shriners system to share clinical and administrative best practices.

(See Project Description Nº 15)

Establishing communication channels conducive to the effective circulation of information, both vertically (between hierarchical levels) and horizontally (between colleagues), and holding meetings where workers have the opportunity to express their feelings, dissatisfaction, and questions, can help reduce levels of psychological insecurity and tension. In fact, employees who are given the chance to express themselves in these ways—as much with their superiors as with their peers—are more likely to be satisfied in their jobs[27]. Among other things, multidisciplinary meetings provide a forum for peer support while reinforcing a sense of collective action, which plays a major role in safeguarding the psychological health of the workplace[61]. In short, communication within an organization is a two-way street: it must function to disseminate information to staff, as well as to listen to them.

The notion of transparency in an organization refers to the state of being open and clear with employees about all aspects of a project, the directions taken by the organization, or other matters. Such transparency in the dissemination of information is very much appreciated and prevents the spread of rumours as well as doubts about the control of information. Transparency can be achieved very simply by supplying the same information to all staff members, whether they be managers or employees[41].

5 5.2 Individual factors

The organizational practices presented above represent tools and strategies that managers can rely on to improve workplace well-being and the institution's performance. It must not be forgotten that, despite favourable working conditions, an employee may still experience psychological discomfort or stress at work. Indeed, a number of individual factors can influence workplace psychological health, such as personality, age, gender, and lifestyle habits.

5.2.1 The influence of personality on psychological health

Some people have personality traits that can impede their ability to enjoy the work experience. It is important to take note of these in order to determine whether measures can be taken by the organization to promote a more psychologically healthy workplace, or whether the problems experienced are more specific to the individual and therefore call for an individual intervention. Many studies have shown a relationship between certain personality traits and how a individual will react to personal and professional challenges.

First of all, a person with a negative affect is more sensitive to negative stimuli in his or her environment and is predisposed to experiencing emotions such as sadness, anxiety, guilt, and hostility. In the work setting, when these individuals perceive a situation to be unjust or inequitable, they become mistrustful and less committed toward their employer. They are more inclined to quit their job than people whose negative affect is less pronounced[62].

Secondly, a person's "locus of control" can colour their perception of events and stressors. Locus of control refers to the extent to which an individual perceives he or she has control over what happens in his or her life. More specifically, individuals who have an internal locus of control consider themselves to be in control of their lives and events. Conversely, a person who has an external locus of control believes that they have no control over any given event[63]. Someone who perceives a lack of control over events is likely to feel despair and is therefore more predisposed to depression. Many studies have demonstrated a correlation between internal locus of control and reduced psychological distress.

Thus, individuals who are exposed to the same environmental conditions may present different psychological, physical and behavioural reactions, depending on their personality traits.

5.2.2 How age and gender factor into psychological health

An individual's gender and age can have an impact on his or her psychological health. In fact, these individual characteristics are significant determinants of one's predisposition to psychological vulnerability.

The risk of presenting with major depression varies between 10–25% in women, compared to 5–12% in men. The literature indeed confirms that women are generally more inclined to suffer from psychological distress.

Two hypotheses could account for this finding. The first suggests that women are more exposed to stress in daily life due to the fact that they play a greater number of demanding social roles (i.e. work–family conflict), and that they often have jobs wherein they have little autonomy and that are emotionally demanding (such as those in the helping professions)[27]. The second hypothesis posits that women are simply more vulnerable to the experience of stress of daily life[64].

Age can also influence the presence of psychological health problems. For example, the average age of onset of depression is approximately 35[27].

5.2.3 The impact of lifestyle and dependency on psychological health

Healthy lifestyle habits can improve individuals' ability to cope with the various constraints they face on the job. (See Part 3, Chapter 3, *Promoting a Healthy Lifestyle in the Workplace*, p. 120).

Conversely, people who engage in few activities outside of work, neglect their diet, and do not get sufficient physical exercise reduce their capacity to cope with stress[26]. The main lifestyle habits that are harmful to health are smoking, poor diet, sedentariness, and alcohol consumption[53]. The acquisition and perpetuation of these lifestyle habits is influenced by an individual's physical, social and economic environments at work, home, with friends, and in the community. Over the long term, certain people may

develop unhealthy habits that are conducive to damaging their professional and personal lives, and abandoning these habits demands effort and perseverance.

Dependency

Dependency is an altered state of psychological health that is defined by a set of behavioural, cognitive and physiological phenomena caused by repeated consumption of a psychoactive substance: strong desire to consume the product, difficulty controlling one's use, continued use despite knowledge of its harmful health effects, withdrawal symptoms during periods of non-consumption, and progressive disengagement in professional, social, and/or family activities[65]. It is worth noting that 39.6% of residents of Quebec, Canada, report having suffered the negative consequences of excessive alcohol consumption by someone close to them. A small number of individuals (4%) report having specific problems related to their own alcohol consumption (e.g. physical health, financial and relationship problems). While such issues are disturbing, they are not considered to be persistent in this group and do not generally cause a great deal of suffering. This is not the case for another segment of the population (4%), for whom alcohol is the source of many chronic problems and entails considerable suffering, both for the person concerned and his or her circle. Such cases qualify for a diagnosis of alcohol abuse or dependency (CRPAT, rehabilitation centre for people with drug or alcohol dependencies, 2004). A substance abuse problem can also lead to depression and anxiety disorders, and cognitive damage is frequently observed (CRPAT, 2004).

There are also other types of dependency that do not involve psychoactive substances, such as pathological gambling, which is defined by the DSM-IV (Diagnostic and Statistical Manual, American Psychiatric Association, 1994) as a "persistent and recurrent maladaptive gambling behaviour... that disrupts or damages family, personal or vocational pursuits." In Quebec, Canada, four out of every five adults reported having played a game of chance in 2001–2002[66]. Of this number, 0.8% would be diagnosable as pathological gamblers and another 0.9% would be considered at-risk or problem gamblers[66]. As such, 1.7% of the Quebec adult population who play games of chance present with a potential risk for problem gambling. According to numerous studies, the behaviour of excessive gamblers typically has consequences that affect their personal relationships, job, the family's financial stability, as well as their physical and psychological health[67].

TAKE ACTION

- **Clearly demonstrate the institution's openness to offering support to employees who need it;**
- **Encourage staff to consult a professional about their problems;**
- **Encourage managers to practise active listening and demonstrate open-mindedness toward employees;**
- **Be vigilant for signs of lack of motivation at work, depression or dependency.**

Institutions that wish to prevent and control consumption problems in their setting must employ a strategy that involves collective action that supports the considerable initiative required of the individual. As such, information and awareness activities aimed at dispelling false notions and removing the taboos surrounding dependencies must be carried out. Such initiatives are far more likely to be embraced by staff if done in a spirit of guidance and support[65].

When it comes to intervention, a range of options exists to meet different needs. In Montreal, Canada, services are provided by a variety of institutions: CSSSs, hospitals, addiction and rehabilitation centres, community organizations, and private organizations. Healthcare institutions can thus direct their employees to treatment programs offering support activities, therapy or interventions for pathological gambling, outpatient detoxification, rehabilitation, replacement therapy, family support, and inpatient detoxification in a hospital environment.

Whether it be through awareness or prevention, treatment or repression, the issue of dependency is taken very seriously by French society. Nonetheless, since 1970, the number of users of psychoactive substances in France has multiplied by a factor of 10 to 20. Numerous other European stakeholders have also joined in the fight against dependency, in particular through the anti-drug strategy adopted by the European Union.

5

SUGGESTED WEBSITE

Training: Identifying the risks of addiction in the workplace

The goals of this training program offered by the INRS (French national institute of research and safety for the prevention of workplace accidents and occupational illnesses) are, first, to outline of the basic understanding of various kinds of dependencies and their effects and, secondly, to advise institutions on the implementation of an occupational risk-prevention initiative for dependencies.

Source: www.inrs.fr (in French only)

To manage the individual factors that can be detrimental to employee psychological health, many organizations have instituted employee assistance programs (EAPs). These types of programs are frequently used to ensure the health of the organization. They are designed for employees who suffer from personal problems that are not necessarily caused by the work environment but that affect their job performance. The International Employee Assistance Professionals Association offers the following definition of an EAP: "a worksite-based program designed to assist [in]... identifying and resolving personal concerns, including, but not limited to, health, marital, family, financial, alcohol, drug, legal, emotional, stress, or other personal issues that may affect job performance."[68] Their use is often limited to interventions related to pre-existing problems; however, they can be an effective preventive tool.

In addition to EAPs, other efforts can be made by the healthcare institution to help employees who are suffering from personal problems.

Inspiring initiative

The National Institute of Occupational Health of the Fodor József National Center for Public Health (NCPH-NIOH) – Hungary

This project was conducted under the direction of a team of two specialist occupational health and hygiene physicians and a holder of a PhD, all of whom are experienced in workplace health promotion. Information, counselling and anti-smoking programmes were provided through the occupational health service. In order to improve the attitude of employees toward sports and exercise, the employer built a tennis court. Healthy eating habits were also promoted through the selling of seasonal fruit to employees in their workplace.

Source: www.enwhp.org

5.3 Community and political factors

Society is clearly becoming more and more concerned with the physical and psychological health of its workers. The social and community dimension represents a determining factor in health, particularly with respect to access to health services, community organizations, housing and education. At the political level, the creation of laws, regulations and standards greatly influences the culture of health promotion.

While While it remains a challenge to have workplace psychological health problems recognized as a form of workplace accident or occupational illness, national prevention organizations such as the National Institute for Occupational Safety and Health (NIOSH) in the United States, and the Health and Safety Executive (HSE) in the United Kingdom are pressing organizations to implement preventive strategies. In addition, the European Network for Workplace Health Promotion (ENWHP) issued the Barcelona Declaration on the development of good workplace health practices and the Luxembourg Declaration on the promotion of health in the workplace in the European Union (ENWHP, 2007).

In order to facilitate organizations' promotion of psychological health in the workplace, the Quebec standards bureau (BNQ), Canada, has issued a standard regarding prevention, promotion and organizational practices that promote workplace health[69] (See Part 2, Chapter 2, *Certification and Accreditation... a Framework for Action*).

The Canadian province of Saskatchewan has greatly expanded the scope of workplace health and safety through *The Occupational Health and Safety Act*. This law now provides for the highest standards of promotion and maintenance of the physical, mental and social well-being of workers; the prevention of workers' decline in health due to working conditions; the protection of workers through the elimination of factors that are harmful to health; the establishment and maintenance of working conditions that are adapted to the physiological and psychological status of each individual worker; and the promotion and maintenance of a workplace free from all forms of harassment[70].

FIND OUT MORE

World Health Organization
www.who.int/mental_health/
The WHO directs and coordinates health policy within the United Nations system. It is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends.

European Network for Workplace Health Promotion (ENWHP)
www.enwhp.org/
International agency that promotes the establishment of effective workplace health promotion practices and aims to have these practices adopted in all workplace settings throughout Europe.

European Agency for Safety and Health at Work
www.osha.europa.eu/en
Set up in 1996 by the European Union and located in Bilbao, Spain, EU-OSHA is the main EU reference point for safety and health at work.

Institut national de recherche et de sécurité (French national institute for research and safety) for the prevention of workplace accidents and occupational illnesses
www.inrs.fr (in French only)

National Institute for Occupational Safety and Health (United States) – Stress at Work
www.cdc.gov/niosh/topics/stress/
A section of the NIOSH website that provides information on current NIOSH activities in areas, such as work, stress and health, as well as access to resources to help prevent stressful working conditions.

Health Canada Environmental and Workplace Health
www.hc-sc.gc.ca/ewh-semt/occup-travail/work-travail/index-eng.php

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Chapter 2

IMPROVING EMPLOYEES' PHYSICAL ENVIRONMENT AND MAKING IT SAFER

Key Points

- Consider the multifactorial nature of accidents when assessing risks and seeking solutions. The causes of any accident can generally be found in at least one of the following categories: personnel, task, management, environment, material.
- Develop a global vision and implement "local" actions (at the unit level or for a specific category of employee).
- Take the specifics of each work context into consideration.
- Eliminate risks at source rather than having to manage them.
- Don't blame the employees, but work in collaboration with them to involve them in the process.
- Training alone is not enough. The approach selected must be multi-strategic and impact the work situation as a whole (physical environment, organizational environment, awareness level, etc.).
- Work reintegration programs must be flexible, adapted to the needs of the employee concerned and operate with the full cooperation of all the players involved.
- If no changes are made to the work conditions, the accident risk will resurface.

1 Introduction

"If you've ever wondered how people can manage to work with the sick and always stay healthy themselves, the answer is that they can't."

– Stellman, 1977[1].

The field of occupational health and safety involves risk factors for work-related injuries that are present in the workplace. In this context, the procedural goal is to provide employees with safe working conditions, and thus to reduce both the number and severity of work-related injuries, whether through industrial accidents or occupational diseases, as well as any resulting after-effects.

Whatever the country, the sector with one of the highest rates of work-related accidents is healthcare.

The consequences of these accidents include absenteeism (short or extended), the development of occupational diseases, and job transfers or career changes[2]. This has repercussions on patient care, and leads to understaffing, a rise in staff turnover and higher costs (replacing absent workers, compensation). The human and financial impacts of a workplace accident are outlined in Appendix 1.

It has been observed that accidents occur less frequently in companies where a prevention program is in place[3]. In order to be effective, these programs must offer an integrated approach to prevention; in other words, they must offer a range of procedures that aim to identify and

reduce risk[3]. These procedures include monitoring the quality of the workplace and of preventive measures for maintaining equipment, and implementing measures that allow standards and regulations for health and safety in the workplace, as well as hygiene and safety standards specific to the institution, to be respected[3]. A good prevention program incorporates the identification of protective measures that comply with regulations and are adapted to the needs of workers, improvements in the workplace environment, post-accident investigations, and adequate provision of information and training in workplace health and safety to employees[3].

Definitions

- **Injury[4]:** a harmful effect on health resulting from exposure to chemical, biological, physical and/or psychosocial factors in the workplace, as well as factors related to the way work is organized.
- **Work accident[5]:** any unforeseen event, including acts of violence, arising from the work or occurring in the course of carrying out the work and that leads to a bodily injury, an illness or death for one or more workers.
- **Risk[4]:** the probability of the occurrence of a dangerous event combined with the severity of the personal injury or damage to health caused by such an event.
- **Incident[4]:** a dangerous event related to the work or arising in the course of the work, but not involving bodily injury.
- **Occupational disease[5]:** a disease or illness contracted following exposure to risk factors as a result of work-related activity.

The main risks to which workers in healthcare institutions are exposed generally fall into the following categories[6, 7, 8, 9]:

- **Ergonomic:** resulting mainly from the manual handling patients, the kinetics of certain medical apparatus, and procedures carried out in uncomfortable positions
- **Biological:** such as infections resulting from needle punctures or cuts (scalpel, other instruments), contact with contaminated waste or soiled linens, direct contact with infected patients
- **Chemical:** exposure to disinfectants, cleaning products, anaesthetic gasses and certain medications
- **Physical:** poor ventilation, hot and humid environment, noise, exposure to ionizing radiation, electrical hazards, etc.
- **Psychosocial:** violence (including harassment), stress.

These risks may be amplified by the altruistic attitude of healthcare workers themselves, who traditionally make the care and well-being of patients the priority, even at the expense of their own health and well-being. Added to this is the fact that important protective and preventive measures may be forgotten or deliberately omitted in a serious emergency situation[10]. Staff shortages, overwork, lack of training, and the stress generated by these conditions may also increase these risks.

The risks are presented in greater detail in Section 7, *Types of risk and means of action* (p. 100).

a List of sectors studied: agriculture, manufacturing, construction, wholesale retail trade, hotels and restaurants, transport, real estate, public administration, education, health and social services, others[11].

3 Some statistics

Whatever the country, the healthcare sector has been identified as a dangerous place in which to work[9]. In 2000, one in three (32%) healthcare professionals and social workers in the European Union felt that their work led to risks to their health[9]. In Europe, the health and social services sector is considered to be one of the riskiest sectors[a] in terms of work-related accidents and illness[11].

In the United States, the number of workplace accidents and occupational diseases in the healthcare sector is on the rise. The rate of workplace accidents for healthcare workers has been increasing over the past few years; in comparison, two sectors considered particularly risky, agriculture and construction, are safer now than they were 10 years ago[12].

Table 1 below shows the non-fatal injury rates for 100,000 workers in the health and social services sector in countries for which these data are available.

However, it is generally difficult to establish comparisons because the sources of data may vary from country to country, as indicated in the cautionary note accompanying the statistics below. In addition, we see no general trend in the number of compensated injuries during the period represented.

Table 1 – Number of compensated, non-fatal injuries among 100,000 insured workers (male and female) in the Health and Social Services sector from 2000 to 2008[13]

COUNTRY	2000	2001	2002	2003	2004	2005	2006	2007	2008
Canada[I]	2182	2299	2179	2096	2024	2031	1972	1849	1893
Spain[I]	1316	1329	1277	1422	1414	1387	1397	1215	1226
Estonia[I]	120	99	79	69	88	101	106	96	n/a
Finland[I]	376	328	339	402	399	451	499	515	n/a
France[I]	n/a	n/a	n/a	n/a	n/a	3462.2	3662.2	3797.6	n/a
Italy[I]	2373	2506	2453	2402	2338	2442	2352	2371	2389
Luxembourg[I]	n/a	n/a	3998	3980	6885	n/a	n/a	n/a	n/a
Norway[II]	1474	1377	1237	1159	1137	1065	945	865	711
United Kingdom[II]	579	552	526	548	495	498	504	n/a	n/a
Sweden[III]	1200	1005	1052	956	951	908	937	762	686
Switzerland[I]	939	948	1054	1047	990	986	963	970	983

[I] Source: Insurance file ISIC-Rev.3
[II] Source: Labour inspection file ISIC-Rev.3
[III] Source: Legislation ISIC-Rev.3
ISIC-Rev.3: International Standard Industrial Classification, for all sectors of economic activities

Cautionary note: "Care should be taken when using the data provided in these tables, particularly when making international comparisons. The sources, methods of data collection, coverage and classifications used differ between countries. For example, coverage may be limited to certain types of workers (employees, insured persons, full-time workers, etc.), certain economic activities, establishments employing more than a given number of workers, cases of injury involving the loss of more than a certain number of days of work, etc."[13]

An initial profile of your institution

4

There are several factors to consider at the start of your process; these will give you an idea of the occupational health and safety conditions within your institution.

Indicators:

In order get clear picture of the current situation at your institution, the following indicators should be considered[5, 14]:

- The number of accidents;
- The number of occupational diseases or illnesses;
- The job categories most affected;
- Data on the injured person: gender, age, occupation, position within the organization's hierarchy;
- Data on the injury: fatal or non-fatal injury, type and severity of the injury, site of the injury, number of days off work;
- Data on the accident: location, date, time, mode of injury, material agent that led to the injury, what the injured person was doing when the accident occurred;
- Nature of the occupational disease or illness;
- Data on the exposure;
- Risk factors for occupational disease or illness;
- The number of reported acts of violence;
- Recurrence of accidents, diseases/illnesses or acts of violence.

These indicators are generally easy to obtain, because they already appear in various management charts, statistical reports, workplace health and safety reports, etc., drawn up by the institution.

Reports from the insurance company or the list of reports made to the organization in charge may also be consulted.

Comparing the results either with statistics from previous years, against existing standards, or with the results of institutions comparable to yours will help you sort out the priorities.

In addition, these statistical data may be used for other purposes, such as[5]:

- Determining changes in distribution and incidence of occupational injuries so as to monitor the progress made in terms of safety, and identifying any new risks in future;
- Informing employers and workers of the risks associated with their work and their workplace, so that they can take an active role in ensuring their own safety;
- Evaluating the effectiveness of prevention measures;
- Estimating the cost of occupational injuries, particularly in terms of workdays lost and associated expenditures.

Completing the picture – assessing the risks:

To obtain information that builds on the statistics, we suggest that you conduct discussion or focus groups that will allow you to understand the exact circumstances surrounding accidents, and thus determine the real difficulties that employees are encountering. In effect, such accidents are very often not isolated events, but rather the consequences of a particular work context that must be understood before changes leading to the reduction in the number and severity of the accidents can be made. Gathering information about these events may also lead to measures that will prevent an accident from happening in the first place.

Risk assessment must be done in a very precise manner for each department, each job position and each work shift (without forgetting the employees who work with patients in their homes). The fact is that the risks to which employees are exposed are highly dependent on their work context.

A sample risk assessment form is presented in Appendix 2.

4

Particular attention must be paid to certain groups of employees who may present an increased accident risk: people with a disability, inexperienced workers, women who are pregnant or breastfeeding, immigrants, employees with pre-existing health conditions, young employees, or older employees[15]. For more information on this subject, please refer to the chapter entitled *Taking Action to Reduce Social Inequalities in Health in the Workplace* (p. 138).

Lastly, accident investigation reports may also be consulted; these will provide more details about the circumstances surrounding certain types of accidents and will inform your decisions.

For more information on the areas that you have identified as priorities and to help in drawing up your action plan, we suggest that you look at the approach proposed in the chapter entitled *A Process for Implementing Healthy Workplaces* (p. 20).

All factors related to achieving a successful program must be contained in your action plan (e.g. a participatory, multi-strategic, integrated approach focusing on a targeted population, etc.)

Updating the risk assessment:

Risk assessment must be repeated on a regular basis to ensure that the modifications introduced are effective and that the introduction of new elements has not led to new risks. These new elements may include[16]:

- The start of a new project;
- A change in working or operating procedures;
- A change in or addition of tools, equipment, machinery (including a change in location or method of use);
- The arrival of new employees;
- A move into a new building or new workspace;
- The introduction of new products or chemical substances;
- The acquisition of new information about a product already in use.

SUGGESTED READING

Canadian Centre for Occupational Health and Safety (CCOHS). (2009). *Risk Assessment*. www.ccost.ca/oshanswers/hsprograms/risk_assessment.html

Drawing up an inventory of existing resources related to occupational health and safety

Institutions have abundant resources in the form of committees (including union committees), groups or initiatives. These committees may deal with particular themes such as occupational health and safety, risk management, quality control, infection prevention, management of waste material, etc.

To ensure integration and coherence, the action plan must take all of the regulatory levels into account. To this end, it will be useful to thoroughly survey the various regulatory mechanisms and clarify their purpose and structure in order to gain a global understanding of the dynamics involved and understand how each employee fits into this complex framework. The links among these different resources must also be explored.

The action plan must help to clarify and simplify this structure, rather than be just another source of standards and directives.

This exercise may also help to identify the key players in each area and reassure them with respect to their involvement in the process (participation in the working committee, dissemination of information to their co-workers, etc.).

A more detailed assessment

5

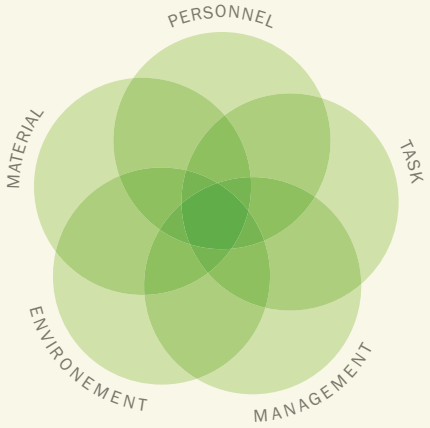
Analyzing the results obtained from the initial survey of your institution will help to highlight your priorities for intervention, based on the severity, frequency, and scale of the injuries. Priorities for intervention may relate to groups of employees, specific units or the types of occupational injuries sustained.

In order to better understand the circumstances surrounding an accident, a more detailed assessment must be made, one that will take into account all the factors existing at the time of the accident.

5.1 The multifactorial nature of accidents

Even though some accidents may appear very simple, there is almost never one single cause. Factors such as working in an emergency situation, stress, fatigue, level of experience, the way the workplace is organized, understaffing, etc., must also be taken into account. Generally, the causes of any accident can be grouped into five categories: personnel, task, management, environment and material[17] (see Figure 1). In almost all accident cases, elements from several categories are to blame.

Figure 1 – Accident Causation in the Organization[17]



Safety in the execution of a task depends on the characteristics of each element of the work situation. Here are some of elements that invite examination[17]:

Personnel: Physical and mental condition of the individuals involved

> Employee experience;
> Level of training;
> Health status and physical capacity to carry out the work;
> Stress level;
> Etc.

Task: Work procedure

> Safe work procedure used;
> Appropriate tools and materials made available to personnel;
> Properly functioning safety devices;
> Etc.

Management: Definition of management systems used

> Communication of relevant safety rules to employees and checking to ensure they are properly understood;
> Enforcement of procedures;
> Adequate supervision of the work;
> Training adapted to the employees for executing the work;
> Etc.

Environment: physical environment at the time of the accident and any recent modifications to that environment

> Cluttered workspace;
> Noisy environment;
> Sufficient lighting;
> Etc.

Material: potential causes associated with the equipment used

> Equipment failure;
> Cause of the failure;
> Correct use of machinery;
> Etc.

5

Other tools

Other tools may also be used to reveal the multifactorial nature of an accident.

> The Tree of Causes Method[18]

The tree of causes is a tool for analyzing accidents that provides a graphic reconstruction of the events that directly or indirectly led up to the injury. Its use, which is relatively simple, allows the situation to be corrected immediately, the underlying causes to be identified and remedied, and any similar potential risks in other areas of the institution to be eliminated (see Appendix 3).

> Haddon's Matrix[19]

This model, a little more complicated to use, can be applied to more complex accident situations for a more detailed, more precise analysis, allowing the circumstances of the accident to be better understood (see Appendix 4).

Project

***An Individual Approach to Risk Factors for Employees* – East Tallinn Central Hospital – Tallinn, Estonia**

The purpose of this project is to promote a safe, healthy workplace. The aim is, on the one hand, to make each employee aware of the risk factors to which he or she is personally exposed, and on the other, to put in place preventive measures throughout the hospital, adapted for each employee. For this purpose, the working committee created an "Individual Risk Factor Chart" that lists the specific risk factors to which each employee is exposed. This chart is filled in by the Work Environment Department, as well as the staff doctor. During health evaluations, the staff doctor issues recommendations to each employee. The immediate supervisor is responsible for the implementation and follow-up of these recommendations.

(See Project Description Nº 16).

5.2 Risk assessment and intervention – integrated risk management

Integrated risk management can be defined as a "steady, continuous process, coordinated with and integrated into all of the organization's systems and subsystems, that allows risks and situations deemed to be risky and that have caused or may cause damage to the user, to the visitor, to personnel, to goods, materials and equipment belonging to them and to the institution, to be **identified**, **analyzed**, **monitored** and **evaluated**."[20] [Translation]

Various tools are available in different countries. At the international level, we would mention in particular the International Organization for Standardization (www.iso.org), which offers the *ISO 31000: 2009* guidelines, and the International Labour Office (www.ilo.org), which offers the *ILO-OSH 2001* guidelines.

These tools offer approaches designed to allow institutions to improve their performance in managing occupational health and safety.

5.3 Risk assessment and intervention – participatory ergonomics

Participatory ergonomics may be included in the integrated risk management process. It consists of an intervention process for which numerous studies have demonstrated positive results[21, 22]. It may be used not only to prevent the occurrence of an occupational injury, but also to facilitate the injured employee's return to work. Ergonomists and the employee affected work together to define the latter's work situation. This approach gives employees the opportunity to have an impact on the design of their workplace environment and a hand in the planning of their activities. The basic assumption is that employees have a very thorough knowledge of their workplace, which allows them to develop an approach that is more responsive to change, and one in which procedural changes can be implemented, all with the aim of preventing risk[22].

This approach must not be used systematically but, instead, in a specific way for certain complex issues that require a major reorganization of the work area.

Features of the participatory ergonomics approach[21]

> Creation of a diverse committee made up of workers, managers, occupational health and safety representatives and ergonomists;
> Training of personnel by ergonomists on the principles of ergonomic analysis in the workplace;
> Pooling and comparing of knowledge between ergonomists and personnel;
> Implementation of the improvements identified by the committee.

Key factors for a successful participatory ergonomics approach[23]

> The working group must comprise appropriate members as well as key players in the approach: staff, supervisory personnel, ergonomics specialists, union representatives, health and safety advisors, the head of the department concerned, etc.;
> It is important to identify the factors that can either bolster or impede the approach (support from the organizational hierarchy, the human and financial resources available, etc.);
> Training in ergonomic methods must be offered;
> The person coordinating the approach must be a recognized expert in his/her field;
> The participants' responsibilities must be clearly defined (diagnosing the situation, defining solutions, implementation and follow-up);
> Decisions must be made through consultation within the group.

6 Principles

6.1 Overall vision of the institution

An integrated and coherent action plan must work in conjunction not only with all the elements that affect safety in the workplace, but also with the institution's overall approach to promoting a healthy workplace. The action plan must also be consistent with the institution's main objectives, and share in that approach.

The action plan must be comprehensive, integrated and consistent with the different elements associated with the theme of a physically safe environment, and with the institution's main objectives.

6.2 Taking specifics into account

It is essential, particularly in this process, to have a clear understanding of the working realities for different categories of employees in various departments and units. This analysis will provide a more rigorous understanding of the circumstances surrounding accidents as well as risk factors for occupational diseases, and will consequently help identify solutions that are context-specific.

The risks faced by employees vary greatly in terms of their job title, their work shift and, above all, the department in which they work. It is therefore very important to take into account the workers' specific context when seeking to prevent occupational injuries.

A comprehensive action plan must also take into account the workers' specific context (in terms of department, job title, work shift).

6.3 Multiple standards

The work of each category of employees in the healthcare system is governed by a large number of laws, standards and guidelines, all issued at different levels and by different organizations. Workplace safety is also monitored and controlled by different groups, associations or commissions, all of which seek to make sure that the environment in which the employees work offers a high level of safety at all times (including the safe integration of new techniques or new practices). As such, healthcare workers are subject to numerous concurrent regulations, controls and supervision.

The laws, regulations and directives concerning occupational health and safety are issued at different levels of decision making by various types of organizations, including and especially by government, professional associations (or professional orders), institutions themselves and even some of their own units, departments or services.

In addition, during their training (whatever the job title may be), future graduates receive information about protecting their physical integrity – for example, the guidelines for stretcher-bearers with respect to moving patients

safely, or techniques for the nursing staff when giving injections or taking samples.

International organizations such as the International Labour Office of the International Labour Organization (UN agency) also offer directives related to occupational health and safety.

Finally, certification and accreditation programs themselves establish standards, some of which relate to occupational health and safety, with which institutions must comply in order to be certified or accredited. See *Certification and Accreditation... A Framework for Action,* p. 42).

The action plan must incorporate as many of these directives as possible. It should not constitute a constraint, but should instead help employees to apply the standards.

6.4 Non-compliance with the standards

We are devoting a specific section to non-compliance with standards, as this type of behaviour is often misinterpreted.

On the one hand, years of research in social psychology have taught us that information alone is not enough to change behaviours. On the other hand, the reasons for not complying with standards are many, and often depend on a work context that does not encourage compliance.

Employees must not be blamed, but must instead be encouraged to participate, with full transparency, in the deliberations around this issue, in order for adapted solutions to be put in place.

Here is a **partial** list of the different reasons why standards are not respected, grouped according to the main factors involved:

Organizational factors[24]

> The way in which the work is organized is not conducive to adhering to standards (schedules during which certain procedures must be carried out, etc.);
> Human resource management (no possibility of teamwork when using patient handling techniques, etc.);
> Lack of time for complying with a procedure;
> Absence of procedure;
> Poor communication of information.

- *Actions to consider:*
  - In collaboration with the employees concerned: listing the difficulties encountered in applying the standards; collective thinking about new ways to organize the work that would promote adherence to standards (including finding new, faster procedures that meet the same safety criteria); defining new organizational methods;
  - Distributing information concerning new practices to all employees in the department;
  - Offering support or training with respect to the use of new practices.

Environmental factors

> Layout of the area and the workspace (very full countertop, overlapping of the writing area with the area for preparing nursing trays, nurses' station located at the end of the corridor, etc.);
> Poorly adapted materials or equipment (bed with no height adjustment, doors that do not open automatically in certain zones, etc.);
> Lack of suitable materials or equipment (no transfer board, etc.);
> Contradictory rules from different regulatory bodies;
> Rules not applicable in certain specific environments.

- *Actions to consider:*
  - In collaboration with the employees concerned: listing the difficulties encountered in applying standards; collective thinking about eliminating risk at the source (replacing certain products, changing the layout of the workspace, etc.), so that the work environment facilitates compliance with the standards;
  - With the support of general management (particularly with respect to the purchase of new equipment), making the necessary modifications;

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- Distributing information concerning new practices to all employees in the department;
- Offering support or training with respect to the use of new practices or new equipment.

Personnel factors

> Lack of awareness of the procedure, or failure to remember it;
> Personnel unconvinced of the usefulness of the procedure or of the risk involved;
> Inexperienced personnel[24].

- *Actions to consider:*
  - Training;
  - Reminder notices;
  - Themed week or month;
  - Presentation of statistics on the risks involved;
  - Promotional activities;
  - Meetings, discussions;
  - Mentoring, working in tandem;
  - Knowledge sharing: setting up "professional collectives".

A "professional collective" is a group of employees working in the same sector. The goal of this collective is to share useful information about prevention in their trade or profession, about difficult client populations, and about care techniques. Its existence also plays a support role, particularly when employees work in isolation (homecare, service points that are numerous and far apart). The collective also allows workers to develop collective work strategies and common rules[24].

In order to respond to these different needs, it may also be useful to designate, in each department, a health and safety "reference person" who belongs to the category of employees targeted. This reference person then communicates directly with his/her colleagues, answers their questions when a procedure is forgotten, or forwards certain issues to a superior. Indeed, advice is often better received and followed up on when it comes from a respected peer. In addition, the strategies selected will be much more effective when targeted employees are given the opportunity to participate in the process.

For a more thorough understanding of this issue, refer to the section entitled *Initiating the change* (p. 26).

7

Types of risk and means of action

7.1 Ergonomic risks

Definition

Ergonomic risks are mainly present when carrying out activities such as the manual handling of patients, moving medical apparatus and work done in uncomfortable positions.

The main injuries observed are musculoskeletal disorders (MSDs) of the back and upper limbs (mainly shoulders and wrists).

MSDs are injuries of the articular and periarticular structures, where several types of tissue with different properties may be affected. The term covers a wide range of injuries to the musculoskeletal system, such as[25]:

> Tendinitis (inflammation of the tendons);
> Myalgia (muscle pain and muscle function problems);
> Nerve entrapment syndromes;
> Degenerative injuries of the spinal column (neck and lumbar regions), particularly for employees who manually handle patients or do demanding physical tasks.

These problems usually appear gradually, after prolonged exposure to occupational risk factor, such as awkward positions, monotonous and repetitive tasks, intense physical exertion, problems with workplace organization and non-adapted work, and carrying heavy weights[25].

Note: an increasing number of scientific studies point to psychosocial factors (such as stress) in the work environment as causal factors in the development of MSDs[26].

TAKE ACTION

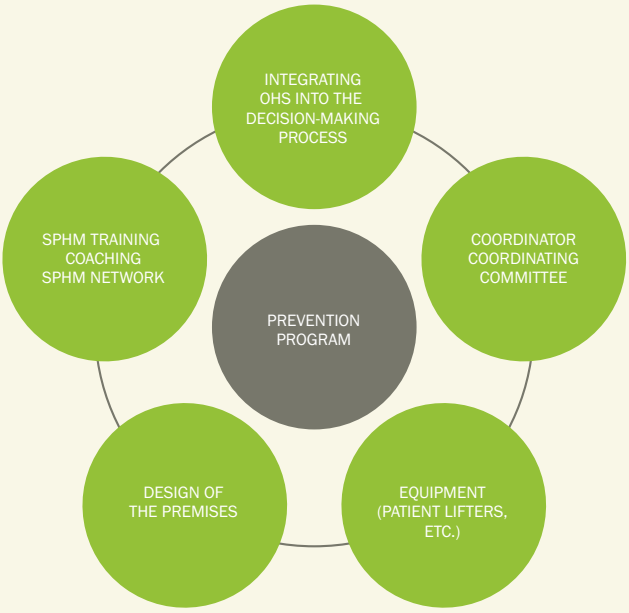
Some data

All studies show that training in safe methods of patient handling has no impact on reducing the number of accidents at work when this training is given in an isolated context[27]. In order to reduce the number of work accidents related to patient handling, using a multi-strategy approach that will impact the work situation as a whole is essential.

In addition, training activities must be offered frequently in order to help employees remember procedures and ensure that new employees are trained.

For example, an MSD prevention program could include the components presented in Figure 2.

Figure 2 – Components of a prevention program for MSDs[28]



OHS: Occupational Health and Safety
SPHM: Safe Patient Handling and Movement

Project

Preventing Musculoskeletal Disorders (MSDs) in Nursing Staff and Caregivers **– East Tallinn Central Hospital — Tallinn, Estonia**

The aim of this project is to prevent MSDs in nursing staff and caregivers who manually handle patients. Several targeted activities were put in place. Training workshops on the principles of safe handling were offered to staff in every department, focusing on the techniques most appropriate to their particular issues and patients. These training sessions are now offered on a regular basis to ensure that all staff members are trained and to update techniques arising from the latest research. In addition, numerous modifications to the physical environment have been made, such as replacing bathtubs with showers, installing handrails on corridor walls and purchasing adjustable electric beds.

(See Project Description Nº 17).

7

7.2 Biological risks

Definition

The known sources of biological risks in the workplace are viruses, bacteria, fungi and plants[29]. The most common means of penetration is through the skin (especially if it is damaged), and via the respiratory and digestive tracts.

The following illnesses, listed in order of frequency, are the main infectious occupational diseases found in healthcare workers around the world: Hepatitis B (transmitted via blood), tuberculosis (transmitted via the air), Hepatitis C (transmitted via blood), Hepatitis A (transmitted via stools)[30]. The following infectious occupational diseases are also pervasive: Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS), chickenpox, measles, mumps and rubella[30].

Personnel may also come into contact with organisms that are resistant to antibiotics, such as multi-drug-resistant tuberculosis (MDR-TB), methicillin-resistant staphylococcus aureus (MRSA), etc[6].

Needlestick injuries are a significant mode of transmission for certain infectious illnesses, such as Hepatitis B and C, and HIV/AIDS[31].

Details

In this chapter, we do not address all the measures for preventing infectious diseases that are used by staff in different institutions (hand washing, disinfecting surfaces, wearing protective clothing, vaccination, etc.), as all these elements are regulated by numerous standards, regulations and protocols.

With regard to the risks associated with poor management of waste material, especially biomedical waste, please refer to the section entitled *Waste management*, (p. 164).

As a practical illustration, we cite the example of needlestick injuries, the approach for which may be used in other contexts.

As the active participation of caregivers is important to the success of any prevention program, user uptake is a critical factor, and one that is often neglected[32].

TAKE ACTION

The example of needlestick injuries[31]

Despite the publication of guidelines and the implementation of training programs, needlestick injuries are still a major problem, especially as several studies have shown that it is possible to prick oneself at any stage while using, assembling and disposing of a needle.

The design of the equipment, the nature of the medical intervention, the working conditions, the experience of the staff, the decision whether or not to recap, and the accessibility of needle disposal sites are all factors that affect the occurrence of this type of accident.

The best way to protect employees from infectious diseases that can be transmissible via needlesticks is to develop, in collaboration with the staff members concerned, a complete, multi-strategy prevention program for needlestick injuries that includes the following activities:

- Training employees;
- Distributing and updating the guidelines concerning exposure to all pathogenic agents transmissible by blood;
- Teaching safe methods of recapping;
- Putting in place efficient, user-friendly mechanisms for needle disposal;
- Developing a surveillance program;
- Ongoing innovation: better equipment design;
- Mentoring employees.

7.3 Chemical risks

Definition

Exposure to potentially dangerous chemical products is a daily reality for healthcare workers. A huge number of chemical products are used by very different categories of workers, in different places (see Table 2).

Table 2 – Categories of chemical products encountered in different departments of healthcare institutions[10]

TYPES OF CHEMICAL PRODUCTS	LOCATIONS FOR USE (THE MOST FREQUENT)
DISINFECTANTS	INPATIENT SERVICES
STERILIZERS	SUPPLY SERVICES SURGICAL WARDS DOCTORS' OFFICES RE-EDUCATION CENTRES
DRUGS	INPATIENT SERVICES PHARMACY
LABORATORY REAGENTS	LABORATORIES
CLEANING AND MAINTENANCE PRODUCTS	ENTIRE INSTITUTION
FOOD PRODUCTS AND INGREDIENTS	KITCHEN CAFETERIA
PESTICIDES	ENTIRE INSTITUTION

Some data

A new system for classifying and labelling chemical products, the Globally Harmonized System (GHS), has been developed at the international level, creating consistency and uniformity in the following areas[33]:

> Classification criteria that allow the dangers of chemical products to be identified;
> Elements for communicating the dangers (label and safety data sheet contents).

It is expected that the international implementation of this new system, which covers the transportation, workplace and food service sectors as well as emergency intervention services, will produce the following benefits[33]:

> Improvements in human health and environmental protection thanks to a system for the communication of dangers that is globally understood;
> Provides an established framework to countries that have no system;
> Reduces the need to carry out tests and evaluations for chemical products;
> Facilitates international trade in chemical products for which the dangers have been properly evaluated and identified at the international level.

Use of this system is not mandatory. The third revised edition was published in July 2009. Implementation is proceeding gradually according to country.

United Nations Economic Commission for Europe (UNECE)
www.unece.org/trans/danger/publi/ghs/ghs_welcome_e.html

7

TAKE ACTION (34)

The huge diversity of chemical substances present in healthcare institutions, and the multitude of locations in which they are used, necessitate a systematic approach. A product-by-product approach to prevent exposures and their harmful effects would be inefficient for a problem of this magnitude.

Apply general principles to control chemical risks:

> Step 1: Identify the risk
  - Knowledge of the physical properties, chemical components and toxicological properties of the chemical products in question;

> Step 2: Characterize the risk
  - What is the nature of the risk (cancer, allergen, etc.), what are the short-term side effects, etc.?

> Step 3: Assess the actual exposure
  - Discussions with the employees groups that use the product;
  - Consultation with an industrial hygienist who will carry out precise sampling procedures.

Set up a monitoring program for chemical products in hospitals:

> Statistics on exposures;
> Statistics on accidental chemical spills;
> Nature of complaints (unusual odour, eye irritation, etc.);
> Number and nature of clinical cases (in a sector or in a given occupational category);
> Traceability and monitoring of the product life cycle.

Improvements can also be made at the source, through the careful selection of products to be used (in particular, paints, cleaning and maintenance products, pesticides, etc.), in order to reduce the impact on the health of employees. For more information on this subject, please refer to the sections entitled *Construction and renovation activities* (p. 167), and *Green procurement* (p. 170).

Project

The Management of Dangerous Drugs at the Sherbrooke UHC – Why and How — **Sherbrooke University Health Centre – Sherbrooke, Canada**

2010 ASSTSAS Conference: *La prévention, comme la magie, ça s'apprend! [Just like magic, prevention can be learned!]*

In January 2005, following the publication of a report by the US National Institute for Occupational Safety and Health (NIOSH), the head of Occupational Health and Safety at the CHUS recognized a discrepancy between the scientific data warning of the risk of exposure to hazardous medications at any point along their route as they circulate through the hospital, the number of protective measures in place, and the employees' awareness of this risk (only staff working in the chemotherapy centre and the oncology pharmacy expressed any concerns). An implementation committee was set up, with formal support from management. Various activities were organized: publication of a policies and procedures manual for the safe handling of dangerous drugs, training of personnel at risk, on-the-ground interventions on demand, environmental monitoring, support for work teams, and making the tools available to help in the application of standards. Environmental monitoring, updating procedures and evaluating training needs are all activities that are carried out on an ongoing basis.

(See Project Description Nº 18).

7.4 Physical risks

The physical risks to which staff may be exposed are numerous. Below, we present the most relevant elements associated with each type of risk, including prevention strategies and tools for monitoring or obtaining information on risk outcomes.

For each type of risk, it is essential that the employees concerned be involved in the process of evaluating needs and seeking solutions. They are the people best placed to correctly identify the sources of risk as well as the corrective measures to be taken, and the success of the approach depends on their adherence to the new measures.

Types of physical risks[35, 36]:

> **Electrical risks**
- Importance of carrying out regular inspections to ensure that electrical installations comply with safety standards and regulations;
- Establishing regular employee training sessions on the safe use of electrical appliances and equipment.

> **Heat**

Monitor work areas:
- In which the temperature is usually the highest: boiler room, laundry and kitchen;
- In which the ventilation and air conditioning systems may be less efficient, such as older buildings;
- In which there are major temperature variations, depending on the season;
- In which the staff must wear protective clothing (masks, lab coats, gloves, personal protection equipment).

> **Noise**
- Aside from reducing the ability to hear, a high noise level may lead to headaches, increased irritability, difficulty in communicating with co-workers, reduced work capacity, and greater difficulty executing tasks that require vigilance, concentration and attention to detail;
- Measuring noise levels in areas where machines generate a lot of noise (boiler room, laundry, technical rooms, etc.), as well as on wards, in offices (printers), in labs, etc.

> **Poor ventilation**
- Importance of encouraging staff to report any irritating reaction that appears only in the workplace (sore throat, runny nose, tearing).

> **Laser fumes**
- During surgery, the thermal destruction of tissue by laser or by an electrosurgical appliance gives off fumes that may contain toxic gasses and vapours, airborne bacteria, living or dead cellular material, and viruses. In large concentrations, the fumes cause eye and upper respiratory tract irritations in healthcare workers and may lead to vision problems for the surgeon;
- Regular inspection of the filters and intakes in the ventilation system of surgical wards is necessary.

> **Ionizing radiation**

Make sure that the safety instructions are respected:
- In designated areas: radiotherapy, nuclear medicine, radiopharmaceutical lab, etc;
- In certain non-designated areas such as intensive care wards, emergency departments, surgical wards, departments in which mobile X-ray machines are used;
- By maintenance and cleaning staff.

> **Non-ionizing radiation**
- Exposing the skin to ultraviolet light causes burns, ages the skin and increases the risk of skin cancer; exposing the eyes can cause transient conjunctivitis;
- The best prevention method is education and the wearing of tinted protective glasses.

> **Lighting**
- Making sure that every employee, regardless of the area in which he or she works (surgical ward, office, laundry, etc.) is provided with sufficient lighting to carry out his/her work under optimal conditions.

7

Consider the areas not traditionally associated with identified risks, as well as all employee groups that could be impacted (maintenance and janitorial staff in particular).

Architecture, ergonomics and working conditions

The architectural design of buildings and units, as well as the work habits of employees, can contribute to a deterioration in working conditions and in the care offered to patients, as these can lead to a number of problems: delays, overlapping of different work areas (care preparation, decontamination, proper storage of materials, storage of waste materials, writing/editing), lack of cleanliness, longer response times, loss of samples, loss of faxes and other documents, etc.

In light of this, it is important that all staff on a unit or in a department think about and air his/her concerns. Resulting modifications must be accepted by everyone, and must respect everyone's working conditions. Many improvements in working conditions can be made just by changing the way work is organized or by reorganizing the work area.

7.5 Psychosocial risks

Only the issue of violence will be dealt with in this chapter.

Stress is such a serious and pressing a problem that it is explored in greater detail in the chapter entitled *Supporting Employee Well-Being and Productive Management Practices* (p. 56).

Given the environment in which they work, healthcare staff are particularly vulnerable to acts of violence. Indeed, health professionals are often the targets of violence at the hands of anxious or disturbed patients, most often in emergency departments and outpatient clinics. In these departments, long wait times and an often impersonal reception can arouse reactions of stress, anxiety and anger, which can easily degenerate into verbal and physical aggression[37]. These workers are also exposed to attacks from parents or friends of patients, which may then cause oversights, delays or errors in treatment, and thus aggravate the patient's condition. In such cases, attacks may be directed at the employee perceived to be at fault, or at any other member of staff in the institution[37].

Definition

According to a study in the United States[37], acts of violence can be divided into three categories:

- Harassment: the creation of a hostile environment through inappropriate words, actions or physical contact not leading to physical attack on an individual;
- Threats: expressions of intent to physically attack an individual;
- Physical attacks: assaults with or without the use of a weapon.

In hospitals, the following areas present the highest risk of violence[38]:

- Psychiatric units;
- Emergency departments;
- Waiting rooms;
- Geriatric units.

Other than hospitals, youth centres and rehabilitation centres for people with intellectual disabilities and pervasive development disorders (CRDITED) are also considered to present risks of violence.

The effects of violence[37]

In addition to physical trauma, the nature of which depends on the type of attack, the victim also suffers psychological trauma, very often with a more serious and more sustained impact (post-traumatic stress disorder, see *Countering harassment and violence,* p. 71). In particular, the victim risks a loss of self-control and self-confidence, doubting his/her professional abilities or even feeling that he or she is to blame for provoking the attack or not having known how to prevent it. These feelings can lead to a sustained lack of self-confidence that may have repercussions on the employee's performance and professional activity. These symptoms may be accompanied

by insomnia, nightmares, absent or excessive appetite, increased use of tobacco, alcohol or drugs, social withdrawal or absenteeism.

Indicators

In addition to the general indicators (number of reports of acts of violence, recurrence of acts of violence, type of violence, consequences, etc.), more specific indicators may be used, such as:

> Frequency of emergency call button use;
> Number of interventions by security staff;
> Number of requests for assistance with potentially violent clients.

It is important to make sure that the measures also cover personnel on evening and night shifts.

SUGGESTED READING

Occupational Safety and Health Administration (OSHA). (2004). *Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers*, U.S. Department of Labor, 44 p. www.osha.gov

TAKE ACTION [34]

Reducing the number of acts of violence [37, 38, 39]

There are several strategies to reduce the number acts of violence:

> Drawing up clear institution-wide directives (zero tolerance for discriminatory, aggressive or violent behaviour);
> Implementing awareness and prevention campaigns;
> Training staff members (warning signs for violence, conflict resolution, emergency measures, techniques for protection, reporting procedures, etc.);
> Reducing the sources of patient stress and anxiety, by reorganizing the work:
  - Putting limits on wait times;
  - Improving conditions while waiting;
  - Giving patients more time to wash, eat their meals, etc;
  - Warning patients in advance of any change in appointments or new treatments;
  - Etc.
> Putting up posters or notice boards directed at patients and employees, reminding people to be patient and stay calm, especially in areas identified as sensitive, such as emergency rooms, lobbies, and certain psychiatric departments;
> Constant presence of security officers in designated areas;
> Specific design features in designated areas:
  - Glazed doors;
  - Emergency buttons;
  - Automatic opening/closing of doors;
  - Open spaces without hidden recesses;
  - Particular attention to lighting, decor, ambient noise;
  - Interior layout of the examination room so that the employee is near the exit door;
  - Consideration of lower-traffic areas, such as stairwells or rooms.
> Implementation of specific safety measures (lighting, security officers, cameras) for:
  - Parking areas;
  - Exterior walkways used by employees: between different buildings; to and from public transit buildings (Metro stations, bus stops); between buildings and parking areas.

7

Under-reporting of violence[37, 39]

Whatever the country or the sector of activity, it is generally recognized that acts of violence in the workplace are very much under-reported. The most frequently stated reasons for under-reporting are:

> Cultural tolerance for violence (trivialization of violence in certain areas, among certain categories of employees);
> Absence of reporting mechanisms;
> Fear of disapproval or reprisals;
> Lack of interest on the part of the employer.

Project

***Fostering a Respectful Workplace and Preventing Violence* – Chatham-Kent Health Alliance – Ontario, Canada**

The purpose of this project is to promote a healthy and safe work environment. The goal is to prevent any occurrence of intimidation, violence, harassment or discrimination by providing employees and managers with the tools to identify, report and/or manage any violent incident in the work environment.

(See Project Description Nº 13).

TAKE ACTION

Increase reporting

In order to encourage reporting, several actions can be taken:

> Upper management must declare a clear position on the issue;
> Simplifying the procedure:
  • Review the procedure for reporting, and modify it if necessary;
  • Provide new, simpler forms;
  • Make sure that evening and night-shift employees have the opportunity to report: mailbox for submitting a report form, resource person who can be reached during their working hours.
> A procedure everyone knows about:
  • Present the procedure at team meetings;
  • Carry out short training sessions;
  • Put up posters and notices in staff areas (staff room, cafeteria), on bulletin boards;
  • Use all institutional communication tools (Internet, intranet, institutional newsletter) to make staff aware of the procedure;
  • Nominate a resource person who can be reached in person or by phone.
> Guaranteed impunity for the person reporting[37, 39]:
  • This condition is essential to the process. In fact, it has to be possible to report in complete confidence, with no fear of discrimination or reprisal (particularly in especially delicate situations of violence between co-workers or with a superior).
> After reporting:
  • Not only must action be taken after each report (the extent and the significance will obviously vary, depending on the situation), but there must be follow-up with the person who reported the incident and with any other individual(s) concerned in this matter. This will provide assurance that the situation has been dealt with, allow the atmosphere at work to return to normal and prevent new incidents from occurring. This will also help to ensure that the person who reported the incident, as well as all other individuals concerned, are in a position to carry out their work properly under existing conditions. In certain situations, it will be necessary to offer the employee who has been the victim of a violent act a transfer to another department.

After an accident

8

8.1 Caring for the employee and carrying out an investigation

Caring for the employee

In addition to the physical consequences for the employee, an accident may have psychological repercussions that vary from serious to relatively mild. (See the section entitled *The effects of violence*, p. 106). In order to limit these effects (physical and psychological), it is important to offer the employee support in order to make sure he or she takes advantage of the services in place to help him or her get the help that he or she may need. These services may involve medical care in the case of a serious injury or infection, psychological care in the case of a traumatic event or a serious reaction in the employee (anxiety, stress), or support during the procedure for reporting the accident. The latter element is crucial, particularly for certain groups of especially vulnerable employees: recent immigrants, part-time employees, new employees, younger employees, or non-unionized employees. In fact, studies show that the proportion of these employees who do not receive financial compensation during an absence due to an accident at work or an occupational illness is much higher than for other, less vulnerable employees[40].

Finally, it is important to have mechanisms in place that will guarantee that these various intervention and support activities take place within a reasonable timeframe, no matter when (during the day, in the evening, at night) or where (main building, service points, patient's home) the accident occurred.

Investigation[17]

An investigation must be carried out following an accident in order to:

- Determine the causes of the accident and prevent similar events from happening in future;
- Satisfy all legal requirements;
- Determine the cost of the accident;
- Verify that all applicable safety regulations were respected;
- Allow employee requests for compensation to be processed.

Incidents that have not resulted in injury or material damage must also be investigated in order to determine what risks need to be eliminated or managed.

The investigation should begin as soon as possible after the accident, so as to maximize the amount of information gathered.

Once the investigation is complete, the data must be analyzed.

SUGGESTED READING

Canadian Centre for Occupational Health and Safety (CCOHS). (2006). *Accident Investigation.* www.ccohs.ca/oshanswers/hsprograms/investig.html

8 8.2 Work reintegration

Work reintegration is a multi-dimensional process. Both the physical work environment as well as the psychosocial context to which the employee will return are factors that must be taken into account.

Physical context

After an accident leading to an absence from work, it may be physically difficult for an employee to return to work under the former conditions. Physical fatigue, pain and physiological issues are also limiting factors. Moreover, if the former work conditions have not been modified, the risk is high that the accident will recur.

Psychological context

Returning to a workplace where an accident (caused by one of the risk factors) has occurred can lead to stress, in addition to feelings of apprehension regarding: recurrence of the accident, aggravation of the physical injury, pain, difficulty reintegrating into the team, lower productivity (physical weakness, forgetting procedures or techniques), etc.

The challenges are great because, should the work reintegration period not go smoothly, the employee runs the risk of accumulating more stress, becoming frustrated and feeling inept at work. All these conditions may then result in a further absence from work[41, 42].

The scientific literature[41, 43, 44] consulted on this subject shows that the implementation of work reintegration programs is clearly beneficial, as much for the employee as for the institution. In fact, certain studies indicate that employees who have taken advantage of such support programs are almost twice as likely to return to work as those who have not. In addition, the number of sick days taken by these employees is reduced by half[43]. While the studies provide no clear consensus on the type of return-to-work program that should be established, a number of features common to these programs have been identified.

Key characteristics of an intervention program to support the return to work[45, 46, 47, 48]

- Intervention is coordinated by a manager in the institution;
- Rapid contact by a support person at the institution (manager, human resources advisor, occupational health and safety advisor, union member, etc.) with the employee who has stopped working;
- Regular contact maintained between the institution and the employee, and characterized by the expression of empathy, in order to establish a gradual return-to-work program, increase the individual's self-esteem, and reassure the employee of his or her progress in the rehabilitation process;
- Concerted action among the various players: employee who has stopped working, family doctor, interdisciplinary team, employer, union representatives, claims adjuster, etc;
- Reducing the environmental constraints in the work area: physical, organizational and relationship constraints;
- Flexibility in the organization of the work and progressive integration of the work tasks for the employee;
- Implementation of training activities for team employees, team leaders and occupational health and safety managers on the participatory ergonomic approach.

Some studies also indicate that the participatory ergonomic approach can facilitate the employee's return to work (see *Risk assessment and intervention – Participatory ergonomics*, page 97).

An adapted return-to-work program

Even though the majority of injured employees do not require any assistance in their return to work, certain employees will need support in order to cope with barriers that are, for the most part, organizational and psychosocial[49].

In addition, one of the studies[44] concludes that workplace intervention programs are more effective for employees who are over 44 years of age, and for employees who have already undergone a work interruption in the past year.

These conclusions suggest that it is inappropriate to follow one single model for a successful return-to-work program. Rather, the program offered must be able to adapt to the needs of the employee.

The process of job reintegration must unfold in partnership with all the other players involved.

This process must be flexible and adapted to the needs of each employee.

If no changes are made to the conditions that existed prior to the accident, there is a risk of recurrence.

Ontario's Institute for Work and Health website:
www.iwh.on.ca/return-to-work-practices

Project

A Well-Organized Program for an Adapted Return to Work (PRATA) — Bas-Saint-Laurent Health and Social Services Agency, CRDI du Bas-Saint-Laurent, CSSS de Témiscouata, CSSS de Kamouraska — Bas-Saint-Laurent, Canada
2010 ASSTSAS Conference, *La prévention, comme la magie, ça s'apprend! [Prevention is like magic; it's easy to learn!]*

A fact-finding study of the human and economic impact of MSDs in healthcare institutions in the Bas-Saint-Laurent region was carried out with a view to mitigating the financial costs related to employment insurance and worker's compensation. What emerged was a self-financed initiative to hire a rehabilitation professional strictly dedicated to working with returning employees. This program (PRATA) has just been added to the existing workplace health promotion services. For each returning employee whose file is retained, a PRATA committee composed of the employee, the employee's supervisor or manager, a union representative and the SST rehabilitation/prevention advisor is set up. The committee operates within a set interdisciplinary framework to resolve problems related to the reintegration of the employee and develops a return-to-work plan adapted to the employee's specific needs. The decisions are made consensually, in a climate of trust.

(See Project Description Nº 19).

FIND OUT MORE

Stellman, JM. (2000). Encyclopedia of Occupational Health and Safety, the International Labour Office, 3rd Edition, Geneva.
May be consulted on the Internet via the SafeWork library (see below)

SafeWork Library
www.ilo.org/safework_bookshelf/english

The SafeWork Library contains the following publications:

- Encyclopedia of Occupational Health and Safety from the International Labour Office
- International Chemical Safety Cards
- Agreements and recommendations from the International Labour Organization in OHS
- Collection of practical guidelines from the International Labour Office

Canadian Centre for Occupational Health and Safety (CCOHS)
www.ccohs.ca

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Appendix 1 – **Table A1 The Human and Financial Impacts of a Workplace Accident**

PARTIES CONCERNED	HUMAN REPERCUSSIONS	FINANCIAL CONSEQUENCES	
		DIRECT COSTS	INDIRECT COSTS
EMPLOYEE	– INCREASED ANXIETY AND STRESS CAUSED BY THE INABILITY TO WORK	– IMMEDIATE LOSS OF INCOME DURING ABSENCE FROM WORK (EXCEPT INSURANCE OR COMPENSATION) – MEDICAL FEES, OTHER EXPENSES RELATED TO THE CARE RECEIVED	– LOSS OF FUTURE INCOME IF THE INJURY CREATES A LONG-LASTING OR PERMANENT DISABILITY, OR HINDERS THE NORMAL CAREER PROGRESSION
FAMILY	– POSSIBLE APPEARANCE OF FAMILY AND CONJUGAL TENSIONS		– FUTURE REDUCTION IN FAMILY INCOME
OTHER EMPLOYEES	– UNEASINESS, ANXIETY AND PANIC – TENSION AND INCREASED WORKLOAD		– PROBABLE LOSS OF INCOME DUE WORK ABSENCE
EMPLOYER	– MANAGEMENT OF POSSIBLE TENSIONS IN WORKPLACE RELATIONSHIPS – DIFFICULTY IN RECRUITING QUALIFIED EMPLOYEES – STRESS, ANXIETY AND INCREASED WORKLOAD – HARMFUL CONSEQUENCES FOR THE ORGANIZATION	– INCREASE IN PREMIUMS PAID TO THE INSURANCE COMPANY (MEDICAL COSTS, COMPENSATION, REHABILITATION)	– WAGE COSTS: – Wages on the day of the accident – Costs resulting from work interruption of other employees or of employees whose work depends on that of the accident victim or on the machinery damaged – COSTS OF MATERIAL DAMAGE – ADMINISTRATIVE COSTS: – General costs associated with the accident – Hiring a replacement – INCREASE IN PRODUCTION COSTS: – Replacement (training period, less productivity to begin with) – Possible reduction in productivity of the accident victim on his return to work
SOCIETY	– NON-PARTICIPATION OF THE ACCIDENT VICTIM IN ECONOMIC, SOCIAL AND POLITICAL LIFE – LOSS OF INVESTMENTS (EDUCATION)	– EXTRA SOCIAL COSTS FOR THE REINTEGRATION OF THE ACCIDENT VICTIM	– FINANCIAL AID FROM THE STATE IN THE FORM OF SUPPLEMENTAL INCOME

Table adapted from: Commission de la santé et de la sécurité du travail (CSST). (2003). *Ma main-d'œuvre, c'est mon affaire! Formation en santé et sécurité du travail [My Labor is my Business! Training in Occupational Health and Safety].* www.csst.qc.ca and adapted from Andreoni, D. (2000). *Work-related Accident Cost,* in Stellman, J.M., Encyclopaedia on Occupational Health and Safety, International Labour Office, 3rd Edition, Geneva, Vol.2, Part VIII, Chapter 56.

Appendix 2 – **Sample Risk Assessment Form**

Here is a model. Make sure you customize it for the needs of your workplace.

NAME OF THE PERSON DOING ASSESSMENT:

DATE:

ACTIVITY/PROCEDURE BEING ASSESSED:

KNOWN OR EXPECTED HAZARDS ASSOCIATED WITH THE ACTIVITY:

THE RISK AND SEVERITY OF INJURY LIKELY TO ARISE FROM THESE HAZARDS:

WHO IS AT RISK?

MEASURES TO BE TAKEN TO REDUCE THE LEVEL OF RISK:

TRAINING PREREQUISITES:

LEVEL OF RISK REMAINING:

ACTION TO BE TAKEN IN AN EMERGENCY:

REFERENCES, IF ANY:

SIGNATURE OF ASSESSOR:

Source: Canadian Centre of Occupation Health and Safety (CCOHS). (2009). *Sample Risk Assessment Form.* www.ccohs.ca/oshanswers/hsprograms/sample_risk.html

Appendix 3 – **The Tree of Causes Method**

The Tree of Causes Method, initially developed by the INRS (Institut national de recherche et de sécurité, France, www.inrs.fr), presents the set of events immediately preceding the accident, together with the logical and chronological links between these events and the accident.

The tree of causes is constructed starting from the end-point of the event – that is, the injury or damage – and working backwards toward the cause by systematically asking the following questions for each antecedent that has been gathered[(a)]:

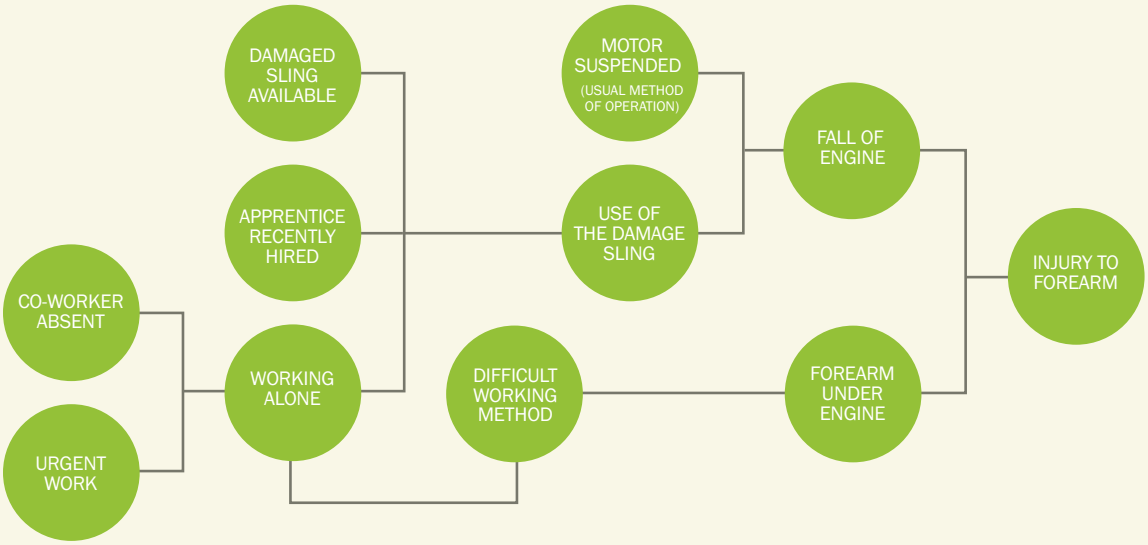
- By which antecedent X was antecedent Y directly caused?
- Was antecedent X sufficient in itself to give rise to antecedent Y?
- If not, have there been other antecedents (X1, X2, etc.) that were equally necessary in order to give rise directly to antecedent Y?

The analysis of the accident is a collective task (drawn up by a working group), comprising the following elements[(b)]:

- Leading the investigation;
- Gathering the facts and only the facts identified;
- Constructing the Causal Tree;
- Seeking corrective measures;
- Determining whether there are similar risks in the institution;
- Proposing appropriate modifications;
- Monitoring their application.

Here is an example of a tree of causes:

Tree of causes of an accident suffered by an apprentice mechanic while remounting an engine in a car[a]



Accident Summary Report[a]**:** An apprentice mechanic, recently recruited, had to work alone in a emergency. A worn sling was being used to suspend an engine that had to be remounted, and during this operation the sling broke and the engine fell and injured the mechanic's arm.

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a Monteau, M. (2000). *Analysis and Reporting: Accident Investigation,* in Stellman, JM. Encyclopaedia on Occupational Health and Safety, International Labour Office, 3rd Edition, Geneva, Vol.2, Part VIII, Chapter 57.

b Eude, M., Lesbats, M. (2010). *Analyser les accidents, Méthode de l'arbre des causes [Analysing accidents, Causal Tree Method],* Département Hygiène et sécurité du travail, Université Bordeaux 1. www.hse.iut.u-bordeaux1.fr/lesbats/H-arbre%20des%20causes/ADC.HTM, Accessed on 19/11/2010.

Appendix 4 – **The Haddon Conceptual Model**

The complex interaction of different risk factors when an accident occurs is also highlighted in the Haddon conceptual model, which offers an analysis matrix with two axes[c]:

First axis: risk or protection factors[d]

- The Host refers to the personal risk of injury;
- The Agent of injury is energy that is transmitted to the host through a vehicle (inanimate object) or vector (a human or an animal);
- The Physical Environment includes all the characteristics of the setting in which the injury event takes place;
- The Social Environment refers to the social and legal norms and practices in the culture and society at the time.

Second axis: temporal axis[d]

- Pre-injury event phase/Primary prevention;
- Injury event phase/Secondary prevention;
- Post injury event phase/Tertiary prevention.

The grid thus obtained reveals the fact that accidents are multifactorial in origin. As a consequence, it would be preferable, whenever possible, that strategies to prevent them or to reduce their seriousness be a mixture of strategies, combining environmental, technological and behavioural modifications[c].

A completed grid is shown in Table A2.

SUGGESTED READING

Public Health Agency of Canada. (1998). *For the Safety of Canadian Children and Youth.* www.phac-aspc.gc.ca

Table A2 – Using Haddon's Matrix to Analyze Injury Prevention

HADDON'S MATRIX	HOST	VECTOR/VEHICLE	PHYSICAL/SOCIAL ENVIRONMENT
PRE-EVENT ACTIVITY	– PREVIOUS BACK INJURY – LACK OF WARM-UP/ MUSCLE IMBALANCE – LIFESTYLE: SMOKING, LACK OF FITNESS/ STRENGTH, ALCOHOL DEPENDENCE	– STORAGE OF MATERIAL IN LOW OR AWKWARD POSITIONS	– WORK CONDITIONS – WORK SITE / STATION DESIGN – PRE-PLACEMENT SCREENING, RECRUITMENT POLICIES/ PROCEDURES
EVENT ACTIVITY	– LIFTING TECHNIQUES – PROTECTIVE DEVICES	– SIZE, WEIGHT AND SHAPE OF LOAD	– ACCESS TO MANUAL HANDLING DEVICES
POST-EVENT ACTIVITIES	– EARLY REPORTING OF INJURY FITNESS – COMPLIANCE WITH TREATMENT/ REHABILITATION PROGRAMS	– AVAILABILITY OF AIDS AND APPLIANCES – MODIFIED EQUIPMENT	– AVAILABILITY OF FIRST AID AND OTHER EMERGENCY ASSISTANCE – REHABILITATION PROGRAMS – RETURN TO WORK POLICIES

Source: University of Minnesota. (2004). *Back Injuries in the Workplace,* PuBH 5120: Injury Prevention Spring Semester 2004, Environmental Health Sciences. Accessed on 19/01/2011. www.enhs.umn.edu/current/2004injuryprevent/back/backinjury.html

c Public Health Agency of Canada. (1998). *For the Safety of Canadian Children and Youth.* www.phac-aspc.gc.ca

d Queensland Government. (2007). *Haddon's Matrix*. Updated on 4/04/2007. www.health.qld.gov.au/chipp/what_is/matrix.asp

Chapter 3

PROMOTING A HEALTHY LIFESTYLE IN THE WORKPLACE

Key Points

- Rely on multi-strategy interventions to reach people: training, education, awareness-building, and individual or group counselling.
- Target multiple lifestyle habits simultaneously. Such programs yield the most significant results.
- Take into consideration the reality of different employees in terms of age, gender, level of motivation, stage of change, etc.
- Facilitate the adoption of healthy lifestyles by making changes to the work environment.
- Maximize the use of available local resources, both in terms of expertise and access to equipment or facilities.
- Remember that group activities not only encourage the adoption of healthy lifestyle habits, but also strengthen bonds between employees.

1 Introduction

The importance currently accorded to initiatives that promote healthy work environments is a reflection of the health concerns of Western populations[1]. Eating healthy, quitting smoking, and leading a physically active lifestyle are prominent issues calling today's employers to action. According to the World Health Organization (WHO), the number of deaths from cardiovascular disease caused by a lack of physical activity or an unhealthy diet could rise by 17% between 2005 and 2015 if nothing is done to reverse current trends[2].

The healthcare costs associated with maintaining unhealthy lifestyle habits—such as sedentariness or poor diet—are manifold, and both direct and indirect costs for the workplace can be observed[1]. Unhealthy lifestyles manifest as risk factors for absenteeism, increased employee medical costs, and a decrease in employee productivity[1].

Workplaces are in a unique position to be able to contribute to positive lifestyle changes through the application of various programs and strategies. In May 2004, the WHO adopted the Global Strategy on Diet, Physical Activity and Health. This strategy notably recognizes the importance of workplace interventions to promote health.

"The workplace environment is clearly identified as an important area of action for health promotion and disease prevention. People need to be given the opportunity to make healthy choices in the workplace in order to reduce their exposure to risk. Further, the cost to employers of morbidity attributed to noncommunicable diseases is increasing rapidly. Workplaces should make possible healthy food choices and support and encourage physical activity."[3]

In O'Donnell's view (2002), very few people are able to maintain a regular exercise program, so the best way to compensate for people's periods of inactivity is to offer them exercise programs at work as well as a work environment that promotes healthy living[1].

This chapter outlines the most important lifestyle habits to target. Moreover, it underscores the factors that will lead to the success of such initiatives because, while many healthy lifestyle programs exist, they are not all equally effective. Indeed, studies have shown that the programs yielding the best results are those that target several lifestyle habits and give equal consideration to changes to be made to the work environment, awareness, education and behaviour changes.

1

Definitions

2

The Public Health Agency of Canada has identified a list of 12 key determinants for human health. Among them are **personal health practices and coping skills**:

"Personal Health Practices and Coping Skills refer to those actions by which individuals can prevent diseases and promote self-care, cope with challenges, and develop self-reliance, solve problems and make choices that enhance health.

[...] *There is a growing recognition that personal life "choices" are greatly influenced by the socio-economic environments in which people live, learn, work, and play."*[4]

Healthy living at a population level refers to group-wide practices that are consistent with preventing the deterioration of, maintaining, or improving health. At the individual level, it consists of practising behaviours that enhance a person's health, or simply living in healthy ways. This includes good hygiene habits, healthy eating, refraining from smoking, maintaining a social network, and keeping physically active. These behavioural choices are largely influenced by people's living environments[5].

The WHO stresses the importance of physical activity and a healthy diet for the prevention of noncommunicable diseases (NCDs)[6]:

"The five major NCDs are heart disease, stroke, cancer, chronic respiratory diseases and diabetes. There is strong scientific evidence that healthy diet and adequate physical activity play an important role in the prevention of these diseases. Furthermore, it is estimated that approximately 80% of heart disease, stroke, type 2 diabetes, and 40% of cancers can be prevented through inexpensive and cost-effective interventions that address the primary risk factors."

3

Literature supporting healthy lifestyle programs in the workplace

The benefits of programs promoting healthy living in the workplace can be observed at various levels—organizational, personal and economic—sometimes even at multiple levels simultaneously. When examined as a whole, these programs most commonly result in the following:

> Improvement in health and change in lifestyle habits;
> Decrease in health problems and associated medical costs;
> Improvement in employee self-esteem;
> Improvement in work team morale as a result of the bonds formed between employees participating in these programs.

With respect to **physical activity and healthy diet**, the following beneficial outcomes are more specifically noted[6]:

> Change in lifestyle behaviours, such as an increase in physical activity and improved dietary habits (increased intake of fruit and vegetables, reduced consumption of dietary fats, weight loss, etc.);
> Reduction in body mass index (BMI) and blood pressure, improvement in cardiorespiratory fitness, and reduction in cardiovascular disease risk factors;
> Reduction in risk factors associated with certain cancers (i.e. those of the digestive system);

3

- Reduced anxiety among those suffering from mild to more serious mental illnesses;
- Improved muscle strength and flexibility;
- Reduction in absenteeism and employee turnover;
- Improvement in employee productivity and morale;
- Improvement in job satisfaction and team spirit;
- Reduction in stress and back pain;
- Reduction in workplace accidents and associated costs.

A recent literature review[7] identified the following outcomes observed across 52 work site physical activity programs:

- Reduction in body mass index (BMI) by 1–2%;
- Reduction in body fat by 10–15%;
- Reduction in systolic blood pressure by 3–10 mmHg;
- Increase in muscle strength and flexibility by 20%;
- Reduction in medical costs.

Moreover, a literature review of workplace **weight management programs** (*Obesity Prevention and Control: Work Settings* in Perrault, G., 2009) demonstrated that multi-strategy approaches involving education, nutrition, diet and exercise prescriptions, self-management tools, group exercise classes, and others, resulted in weight loss ranging from 4-26 lbs among participants (at the six-month mark)[8].

With respect to **smoking cessation** programs, apart from the positive impacts on individuals' cardiorespiratory functioning and other obvious health benefits, Health Canada claims that the employer stands to save costs in several areas. These savings were first noted by William Weis of the Albers School of Business, University of Seattle[9]:

- Health insurance;
- Absenteeism;
- Life and disability insurance;
- Fire insurance, liability and industrial accident insurance;
- Ventilation and energy consumption for heating and air conditioning;
- Legal liability;
- Property damage, depreciation and maintenance;
- Time lost to the smoking ritual;
- Employee morale;
- Corporate image.

A number of studies have found that **stress management**[1] programs help reduce anxiety, muscular tension (though not blood pressure), depression and sleep disturbances. In fact, it is estimated that the positive effects of workplace stress management programs can last three to six months when such programs do not coincide with organizational changes[8]. However, it is also estimated that only 10% of employees persevere in applying the stress management techniques over the long term[8]. Social support and organizational change are proving to be key solutions in helping individuals sustain their behaviour changes over the long term. These programs are usually based on relaxation and meditation. They aim to improve employees' ability to recognize their stress symptoms and manage them more effectively. Nevertheless, if changes are not made at the source of the stress (i.e. work structure), these stress management programs will not succeed in compensating for the prolonged effects of stress, job dissatisfaction and pressure imposed on employees. In such cases, stress management techniques are but a short-term solution. The effects generally associated with these programs are[1]:

- They are beneficial to employees, helping them to reduce certain stress symptoms in the short term and remain actively employed;
- They enable individuals to better cope with stressful situations in their personal lives when at work.

To summarize, here are some key points on what we currently know about workplace health promotion programs:

- They are beneficial in the majority of cases, and a large part of their success rests on a specific set of conditions, which include[7, 10] organizational commitment; a program that is both needs- and evidence-based; incentives for employee participation; a multi-strategy approach; and action taken at the individual level as well as within the work environment;
- Their outcomes for health and for the organization vary according to the lifestyle habits targeted by the program[11];
- Certain programs or activities demonstrate an impact on health and productivity in the short term, whereas the effects of other programs are not measurable until after they have run for several years. It is therefore important to take this into consideration when evaluating a program;
- The outcomes of programs are often mixed (e.g. impact on smoking but not on the consumption of fruit and vegetables[12], effects on physical activity and fatigue but not on overall physical fitness, body fat or hypertension)[11].

Effective strategies and success factors

4

"To take effective action and bring about an appreciable change—particularly when it comes to changing lifestyles—it is imperative to intervene in individuals' behaviours, while at the same time establishing an environment and the life conditions conducive to the adoption of healthy habits. The goal is to 'make the healthy choices enduring, enjoyable and easy to opt for.'"[13] [a]

In order to engage individuals, especially those who are most at risk, we must think about changing the work environment. Individual behaviour change should, of course, be part of any workplace healthy lifestyle program, but it is especially important to intervene at the level of the working environment.

The strategies traditionally used in healthy lifestyle promotion are education (information, workshops, etc.) and regulation (policies, codes of practice, standards, etc.). However, in and of themselves, these actions are not sufficient to get through to every individual in an organization and effect changes in behaviour. Moreover, we must keep in mind that it is generally those employees who are already health-conscious and keen who will participate in such activities right from the start[14].

Consider people's stage of change and work as a team during program implementation.

It is important to take into account an individual's stage of behaviour change in order to truly understand what is likely to motivate or impede his or her personal choices and be able to propose appropriate interventions.

The literature clearly demonstrates the existence of stages of change among individuals[11]. Therefore, programs that are not adapted to employees' stage of change are likely to be less effective. At the same time, it is not necessarily realistic to expect programs to be designed that can address these stages of change systematically. Rather, it is recommended that a variety of activities be offered that will appeal to people at different stages and support their transition to the next stage. For example, an awareness campaign about healthy lifestyle choices may appeal to certain people, while more structured and hands-on programs may be more appropriate for others.

It is therefore vital that organizational stakeholders, external consultants, the institution's senior management, and its managers all be aware of the impact of behavioural change stages on program success and that they take these stages into consideration when:

Conducting a review of the institution's health status or a needs assessment of personnel;

Having to select programs and determine whether they are suited to the profiles of the staff or the particular target employee groups that have surfaced from an institutional health review or employee needs assessment.

The topic of stages of behaviour change is described in detail in Part 2, Chapter 1, *A Process for Implementing Healthy Workplaces* (p. 20).

Costs and anticipated timeframe for achieving results

The cost of a healthy lifestyle change program is estimated to be approximately US$60 to US$150 per employee, including the staff needed to implement the program[1].

The costs of a workplace healthy lifestyle promotion program vary and depend, among other things, on:

- The scope of the program;
- The materials that are readily available versus what needs to be purchased or prepared;
- The current facilities and any renovations that might be needed (e.g. creation of a locker room, showers, etc.);
- The human resources necessary to run the project.

a This is an unofficial translation from French of the original quote.

4

The time required to firmly implement a program is approximately 12 weeks. It should be noted that health promotion programs can sometimes take two to five years before they start to show economic benefits[15].

The key to success: adopting a global approach to health

The scientific literature currently shows a trend within organizations toward adopting a global approach to workplace health[16]. This novel approach involves the implementation of employee health strategies that target several health determinants. Certain workplace healthy lifestyle programs have also adopted this vision and provide activities that promote more than one healthy lifestyle habit at a time. In short, programs addressing multiple lifestyle habits appear to be more effective[11].

In general, the best examples of health promotion programs tend to use a multi-strategy approach that combines[11, 17, 18]:

> Educational activities geared toward raising employee awareness (health education);
> Behaviour change programs;
> Programs aimed at modifying the work environment.

For instance, programs that combine education and access to healthy foods with activities aimed at increasing people's level of physical activity in the workplace are recommended. Multi-component programs that simultaneously target smoking cessation, nutrition, weight loss, exercise and stress management are more profitable than single-focus initiatives[8].

Programs combining smoking cessation, exercise, weight control and nutrition should provide a personalized assessment of risks with feedback regarding behaviour modifications in conjunction with educational activities. Here are some suggestions:

> Conducting a review of the health status of staff and providing feedback individually, face-to-face, by telephone or in groups;
> Written communication;
> Using the Internet to disseminate messages;
> CD-ROMS and automated telephone messages.

It is worth noting that smoking cessation programs that include a counselling component are twice as likely to be effective[8].

Other success factors taken from the scientific literature that merit attention[8, 11]:

> Programs that foster individuals' development of healthy life skills while increasing their social support network are more effective: social cohesion and support at work increase the sense of control employees have over their own health;
> Numerous studies have shown that programs targeting individuals' particular stage of behaviour change stimulate more change than those that do not take these stages into consideration. It is therefore advisable to offer a variety of interventions in order to reach individuals at each stage of change and support their advancement to the next stage;
> Programs can be carried out through counselling individuals face-to-face, over the phone or in groups;
> Programs that include counselling are twice as likely to succeed, especially with respect to smoking cessation and healthy eating programs.

It is also important to keep in mind the conditions that help bolster the success of workplace healthy lifestyle initiatives: involvement of senior management, employee involvement, clearly defined objectives, and evaluation of results. For a more detailed discussion of these factors, refer to Part 2, Chapter 1, *A Process for Implementing Healthy Workplaces*.

To sum up, here are a few important points to keep in mind:

> Develop programs that address multiple lifestyle habits;
> Favour multi-strategy approaches that combine[11, 17, 18]:
- **Educational activities aimed at raising employee awareness (health education);**
- **Programs aimed at changing behaviours;**
- **Programs aimed at modifying the work environment.**

> Include an individual counselling component in the program;
> Account for the stages of change of individuals;
> Adopt a health promotion policy as well as other issue-specific policies (e.g. nutrition policy).

Projects

***Bonus Day to Promote Staff Well-Being* – Raahe Health and Wellness Area – Raahe, Finland**
Four determinants of staff health and well-being were selected as the main goals for this project: remaining smoke-free for a full year, achieving healthy weight (either BMI 28 or less or a weight loss of at least 5 kg), achieving overall good or excellent physical fitness (measured by a walking exercise test or another broader fitness test), and no sick leave days taken during the project year. A "bonus day" consisting of one paid day off at full salary was granted if an employee fulfilled two out of the four goals. In addition, participating staff had to complete an anonymous survey on their lifestyle.
(See Project Description Nº 20)

***Kailo Workplace Wellness Program* – Halton Healthcare Services (HHS) – Oakville, Canada**
Kailo is an employee health promotion approach based on best practices, originally developed at a medical centre in Iowa, United States. This program has been recognized for its excellence by several international and American associations (Joint Commission for Accreditation of Healthcare Organizations, Wellness Councils of America, and the American Hospital Association). HHS conducted a survey among its employees, which gave rise to its five principal workplace wellness objectives. The Kailo approach was chosen at this Ontario healthcare centre to meet the objective of supporting and encouraging employees to make healthy lifestyle choices. The initiative was carried out by a Kailo coordinator in collaboration with HHS managers.
(See Project Description Nº 4)

***Activators* – Oulu University Hospital – Oulu, Finland**
The target group for this project consisted of 30 female employees of the Oulu University Hospital who were at high risk for developing type 2 diabetes. They were selected based on their scores on a risk test for type 2 diabetes. All of them had had a score of over 15 and all were overweight. The aim of the Activator project was to find out whether a group exercise and diet lifestyle-change project would be successful in producing lasting lifestyle changes and diminishing risks for type 2 diabetes. In addition, personal exercise plans to promote better physical fitness were provided, along with nutritional counselling in healthy eating habits to encourage the group.
(See Project Description Nº 21)

Finally, it is important to note that all workplace health promotion programs or activities will be strengthened by adopting a health promotion policy or specific organizational policies that target specific lifestyle habits (e.g. nutrition policy, anti-smoking policy, etc.)[b].

SUGGESTED READINGS AND WEBSITES

Preventing Noncommunicable Diseases in the Workplace through Diet and Physical Activity WHO/World Economic Forum Report of a Joint Event
World Health Organization (WHO). (2008). W.H.O.W.E. Forum, Editor. 2008, World Health Organization/World Economic Forum: Geneva. 51 p.

A site-specific literature review of policy and environmental interventions that promote physical activity and nutrition for cardiovascular health
Matson-Koffman, D., Brownstein, J., Neiner, J., Greaney, M. (2005). *A site-specific literature review of policy and environmental interventions that promote physical activity and nutrition for cardiovascular health*, American Journal of Health Promotion, Vol. 19, n°3, p. 167–193.

b For more information on this topic, you may consult the *Guide to Develop a Health Promotion Policy and Compendium of Policies*, produced by the Montreal Network of Health Promoting Hospitals and CSSSs. Available online at: www.hps.santemontreal.qc.ca

5 Implementing healthy lifestyle initiatives in the workplace

According to the WHO, chronic illnesses are often caused by certain risk factors that are modifiable. These risk factors, which affect women and men alike in all age groups and in every country in the world, are[19]:

> Unhealthy diet;
> Physical inactivity;
> Tobacco use.

Every year, at least:

> 4.9 million people die as a result of tobacco use;
> 2.6 million people die as a result of being overweight or obese;
> 4.4 million people die as a result of elevated overall cholesterol levels;
> 7.1 million people die as a result of elevated blood pressure.

The significant negative impacts of stress reported among healthcare staff are such that we can no longer afford to wait when it comes to lifestyle habits. While the subject of stress management is discussed in detail in Part 3, Chapter 1, *Supporting Employee Well-Being and Productive Management Practices* (p. 56), it also merits attention here as an integral part of any healthy lifestyle program.

Given their significance as risk factors for chronic illnesses as well as their importance in public health priorities, it is essential that the following lifestyle habits be targeted:

> Healthy eating;
> Regular physical activity;
> Smoking cessation;
> Stress management.

In the following sections, we briefly describe each of the above-mentioned lifestyle habits and propose a number of initiatives that can be implemented in the workplace. We must emphasize, however, that for a health promotion strategy to be effective, it must encompass a multi-strategy program that incorporates several lifestyle components.

5.1 Healthy eating

According to the Canada Food Guide, eating the recommended amounts and types of food will enable every person to meet his or her vitamin, mineral and other nutritional needs; reduce the risks for obesity, type 2 diabetes, heart disease, certain types of cancer and osteoporosis; and maintain a state of overall health and vitality[20].

With respect to diet, the WHO has established the following recommendations[21]:

> Achieve an energy balance and a healthy weight;
> Limit energy intake from total fats and shift fat consumption away from saturated fats to unsaturated fats and toward the elimination of trans-fatty acids;
> Increase consumption of fruit and vegetables, legumes, whole grains and nuts;
> Limit the intake of free sugars;
> Limit salt (sodium) consumption from all dietary sources and ensure that salt is iodized.

TAKE ACTION

Examples of what can be done in the workplace[14]:

- **Collaborate with cafeteria managers, food services or caterers to offer healthy food choices and reasonable portions, prices, opening hours, seating capacity, nutrition education, etc.;**
- **Implement a nutrition policy with the institution's cafeteria;**
- **Change the contents of vending machines (maximize water, dairy products, 100% pure juices, vegetable juices, etc.);**
- **Make dining areas pleasant and inviting;**
- **Promote access to nutritional information (e.g. fat, sugar and salt content);**
- **Ensure access to kitchen appliances to allow employees to bring their own meals to work (oven, microwaves, refrigerators, etc.) as well as providing water fountains in dining areas and in close proximity to working areas;**
- **Organize the sale of healthy foods and local products in the workplace by collaborating with community organizations or local producers.**

Project

***Health Comes from Eating Healthy* – S. Maria Nuova of Reggio Emilia Hospital – Reggio Emilia, Italy**

The hospital's nutrition department conducted a survey of the weight of hospital employees at the end of 2007 to identify the prevalence of weight excess and qualify workday eating habits. In 2010, a training course aimed at correcting weight excess and mitigating disease risk factors through nutrition was organized for the entire hospital staff.

(See Project Description Nº 22)

SUGGESTED READINGS AND WEBSITES

Canadian Centre for Occupational Health and Safety – Healthy Eating at Work
OSH Answers: Healthy Eating at Work
This section of the website contains a vast amount of practical information. Among other things, it explains how to implement a healthy eating program for employees.

Health Care Without Harm
Issues: Healthy Food Systems
www.noharm.org/us_canada/issues/food
This website presents a list of healthy, environmentally conscious and ethical alternatives for those healthcare organizations interested in pursuing a healthy food purchasing policy.

The 3 Fives: Five Keys to Safer Food, Five Keys to a Healthy Diet, Five Keys to Appropriate Physical Activity
This document published by the WHO outlines several recommendations regarding food safety, healthy eating and physical activity.
www.who.int/foodsafety/consumer/3x5_SA_en.pdf

5 5.2 Regular physical activity

According to the WHO in the "Why Move for Health" section of its website[22]:

> Every year, at least 1.9 million people die as a result of physical inactivity;
> At least 30 minutes of regular, moderate-intensity physical activity, five days per week reduces the risk of several common noncommunicable diseases (NCDs);
> Physical inactivity is an independent modifiable risk factor for common NCDs.

In its document entitled, *Global Recommendations on Physical Activity for Health*, 2010, the WHO recommends that[23]:

> Adults aged 18–64 years should do at least 150 minutes of moderate-intensity aerobic physical activity throughout the week, or at least of 75 minutes of vigorous-intensity aerobic physical activity throughout the week, or an equivalent combination of moderate- and vigorous-intensity activity;
> Aerobic activity should be performed in bouts of at least 10 minutes' duration;
> For additional health benefits, adults should increase their moderate-intensity aerobic physical activity to 300 minutes per week, or engage in 150 minutes of high-intensity aerobic physical activity per week, or an equivalent combination of moderate- and high-intensity activity;
> Muscle-strengthening activities involving major muscle groups should be done two or more days per week.

TAKE ACTION

Examples of what can be done in the workplace[14]:

> Offer athletic activities that take into account people's schedules (before the work shift, in the morning, over the meal or lunch hour, immediately after the work shift);
> Offer sporadic activities as well a continuous annual program;
> Organize seasonal activities;
> Provide specialized facilities (e.g. bike racks, lockers and showers, a space to store sporting equipment, etc.);
> Be sure to provide a sufficient supply of equipment;
> Post messages to encourage people to take the stairs;
> Disseminate information on the availability of physical exercise programs in close proximity to the workplace as well as activities offered by the municipality;
> Establish corporate partnerships for individuals (e.g. reimbursement of fees, subscriptions, etc.) and groups (e.g. support for work sports teams);
> Promote the use of active transportation.

SUGGESTED READINGS AND WEBSITES

Workplace physical activity interventions: a systematic review
Dugdill, L. A. Brettle, et al. (2008). *Workplace physical activity interventions: a systematic review*, International Journal of Workplace Health Management, Vol. 1, p. 20–40.

Can motivational signs prompt increase in incidental physical activity in an Australian health-care facility?
Marshall, A. L., Bauman, A. E., et al. (2002). *Can motivational signs prompt increases in incidental physical activity in an Australian health-care facility?,* Health Education Research, Vol. 17, p. 743–749.

Promoting physical activity in the workplace: using pedometers to increase daily activity levels
Thomas, L. and Williams, M. (2006). *Promoting physical activity in the workplace: using pedometers to increase daily activity levels*, Health Promotion Journal of Australia, Vol. 17, p. 97–102.

Canadian Centre for Occupational Health and Safety
OSH Answers: Active Living At Work
This section of the website contains a wealth of practical information. Among other things, it explains how to implement a workplace active living program for employees.

The Research File • Physical Activity at Work
The Canadian Fitness and Lifestyle Research Institute and ParticipACTION, Workplace Physical Activity, The Research File, Issue 5 – 05/09 May 2009.
Available online:
www.cflri.ca/eng/research_file/documents/Research_file_09_05.pdf

Work gyms 'lift mood and stress' – Employees who can exercise at work are more productive, happy and calm, a study shows
Longwoods Publishing. *Work gyms 'lift mood and stress' – Employees who can exercise at work are more productive, happy and calm, a study shows*.
Available online:
www.longwoods.com/product.php?productid=20386

Projects

"My Health and Me," a Fun Active Living Initiative for Hospital Staff **– G. Gennimatas General Hospital – Athens, Greece**
The hospital's Health Education and Prevention Office, in collaboration with the hospital manager, initiated a health promotion program for the entire hospital staff with the aim of improving their levels of physical activity and at the same time reducing their levels of work stress. The project involved six hours per week of dance classes and, extraordinarily, the creation of a hospital gymnasium the likes of which did not exist in any hospital in Greece at the time.
(See Project Description Nº 23)

HHS Fitness Centres **– Halton Healthcare Services (HHS) – Oakville, Canada**
In response to answers and suggestions from a staff satisfaction survey, in March 2005, the first HHS-specific fitness centre was opened at one of the Centre's three sites. In November 2006, a fitness centre was opened at the second site, and in September 2009, a last fitness centre was opened at the third site. Staff, volunteers, and physicians have access to their gym 24 hours a day, seven days a week, such that all work schedules are accommodated. There are no user fees, as the gyms were opened and are run on HHS budgets. The design of each fitness centre was based on input from the potential users in order to address the particular needs of the staff, volunteers, and physicians at each site. Each gym contains a variety of fitness equipment, such as cardio machines, free weights, universal weight machines and various others. Additionally, one or more personal trainers come to give fitness classes on a regular basis.
(See Project Description Nº 24)

5

Important note about weight management programs

Managing one's weight is no simple matter. It is influenced by a number of interrelated factors:

> Biology;
> Lifestyle;
> Individual physical characteristics;
> Socio-cultural factors.

Weight management and obesity prevention programs can be offered in the workplace. However, in order for individuals to maximize their chances of persisting with their weight management efforts while mitigating the risks associated with maladapted weight loss methods (weight regain, food cravings, fatigue, etc.), it is important that they seek the advice and guidance of qualified professionals who are certified by professional colleges.

SUGGESTED READINGS AND WEBSITES

The Community Guide: Obesity Prevention and Control: *Worksite Programs*
www.thecommunityguide.org/obesity/workprograms.html
This American organization's Task Force on Community Preventive Services provides a list of work site diet and physical activity programs that have proved effective in reducing weight among employees.

Study: Obesity on the Job
Health Canada. (2005). *Study: Obesity on the Job*. Statistics Canada, 1 p.
Available online at: www.statcan.gc.ca/daily-quotidien/090220/dq090220c-eng.htm

Environmental Influences on Eating and Physical Activity
French, S.A., Story, M., and Jeffery, R.W. (2001). *Environmental Influences on Eating and Physical Activity,* Annual Review of Public Health, Vol. 22, May, p. 309–335.
Available online:
www.uic.edu/classes/psych/Health/Readings/French,%20obesity%20-%20environmental,%20AnnRevPubHth,%202001.pdf

Public Health Strategies for Preventing and Controlling Overweight and Obesity in School and Worksite Settings, A Report on Recommendations of the Task Force on Community Preventive Services
Katz, D.L., et al. (2005). *Public Health Strategies for Preventing and Controlling Overweight and Obesity in School and Worksite Settings, A report on Recommendations of the Task Force on Community Preventive Services,* MMWR, Vol. 54, RR10, p. 1-12.
Available online:
www.cdc.gov/mmwr/preview/mmwrhtml/rr5410a1.htm

5.3 Smoking cessation

In the section of its website dealing with tobacco use, the WHO stresses the importance of reducing the consumption of this substance, which has a devastating impact on people's health. "Tobacco kills up to half of its users... Tobacco use is one of the biggest public health threats the world has ever faced. It kills more than five million people a year... and accounts for one in 10 adult deaths. Up to half of current users will eventually die of tobacco-related disease."

> "The annual death toll of more than five million could rise to more than eight million by 2030 unless urgent action is taken to control the tobacco epidemic;
> More than 80% of the world's one billion smokers live in low- and middle-income countries;
> Total consumption of tobacco products is increasing globally, though it is decreasing in some high-income and upper middle-income countries."[24].

For more information:
www.who.int/mediacentre/factsheets/fs339/en/index.html

It is widely recommended to refrain from smoking or reduce one's cigarette consumption.

SUGGESTED READINGS AND WEBSITES

Best Practices for Smoking Cessation: Implications for Employer-Based Programs
Musich, S., Chapman, L.S., Ozminkowski, R. (2009). *Best Practices for Smoking Cessation: Implications for Employer-Based Programs,* American Journal of Health Promotion, Vol. 24(I1, 1A).

Smoking Cessation and the Workplace: What Physicians Need to Know
Kunyk, D., Els, C., et al. (2008). *Smoking Cessation and the Workplace: What Physicians Need to Know,* Smoking Cessation Rounds, Vol. 2, n°5, p. 6.

The Community Guide: Decreasing Tobacco Use Among Workers
www.thecommunityguide.org/tobacco/worksite/index.html
This page presents the principal findings and recommendations from the organization's Task Force on workplace smoking cessation programs.

Health Canada: Smoking and the Bottom Line: The Costs of Smoking in the Workplace
www.hc-sc.gc.ca/hc-ps/pubs/tobac-tabac/bottomline-bilan/index-eng.php
This website offers a guide to organizations that would like to take action against smoking.

Canadian Council for Tobacco Control – Canada's One Stop Tobacco Control Reference Centre
www.cctc.ca
A wealth of relevant articles and documents can be found through links on this website by entering the keyword "workplace."

Project

Six-Week Non-Smoking Challenge – Sacré-Cœur Hospital of Montreal – Montreal, Canada
This is a biannual project aimed at the approximately 15% of this hospital's staff who smoke. It comprises a communication phase, a registration period, and the challenge phase, throughout which various meetings are held: a meeting with health specialists who speak about the impacts of smoking on health, testimonials from staff who have participated in the challenge before, and discussions among participants.
(See Project Description Nº 25)

TAKE ACTION

Examples of what can be done in the workplace: *(ideas taken from the websites and documents cited in this section)*

- **Establish an anti-smoking policy to reduce tobacco use among staff;**
- **Organize contests with prizes to motivate people's participation;**
- **Offer individual counselling services or support group meetings;**
- **Designate a professional who can circulate among the institution's departments to offer counselling services;**
- **Promote telephone hotlines and other existing smoking cessation support programs;**
- **Organize luncheons or conferences with special invited guests, well-known personalities or influential people within the organization (or outside of it) who have quit smoking.**

5

5.4 Stress management

Throughout the world, employers are becoming increasingly interested in the issue of workplace psychological health as they witness the rise of depression and its consequent loss of productivity. The healthcare sector is particularly affected by this reality.

In Canada, a scientific study found the stress levels of healthcare providers to be directly related to the number of hours worked[25]. Those who worked 35 hours per week or more were much more likely to report high stress levels than those who worked fewer than 35 hours per week. Healthcare providers whose schedule was other than a regular daytime shift were also more likely to report high levels of stress. In another study, two-thirds (67%) of head nurses and nurse supervisors indicated high work stress. Among healthcare workers who reported high stress levels in their everyday lives, 78% also reported high work stress. Similarly, 75% of healthcare providers who indicated they were "dissatisfied" or "very dissatisfied" with their lives also reported high work stress levels[26].

Having good coping skills gives people a sense of self-confidence about being able to solve problems and make informed choices to improve their health. These skills help people overcome life challenges in a positive, constructive manner without having to resort to high-risk behaviours, such as alcohol or drug consumption[2].

To counter workplace stress, it is important to offer services that go beyond addressing the individual's capacities to manage stress. Indeed, to effectively target the sources of stress, it is necessary to develop a component aimed at improving organizational management practices. This topic is discussed in greater detail in Part 3, Chapter 1, *Supporting Employee Well-Being and Productive Management Practices* (p. 56).

TAKE ACTION

Examples of what can be done in the workplace[14]

- **Educate employees and provide them with tools for reducing and managing their stress;**
- **Teach managers to recognize and address the signs of stress in their employees;**
- **Offer employee support programs as a useful resource for both employees and managers;**
- **Adapt management practices to limit the sources of stress.**

SUGGESTED READINGS AND WEBSITES

www.medicinenet.com/stress_management_techniques/article.htm

Scully, D., et al. (1998). *Physical Exercise and Psychological Well-Being: A Critical Review,* Journal of Sports and Medicine, Vol. 32, nº 2, p. 111–120.

Wankel, L. (1993). *The Importance of Enjoyment to Adherence and Psychological Benefits from Physical Activity*, *International Journal of Sport Psychology*, Vol. 24, nº 2, p. 151–169.

FIND OUT MORE

1) **Book:** O'Donnell, M.P. (2002). *Health Promotion in the Workplace,* DELMAR Thompson Learning.

2) **website: Public Health Agency of Canada. Canadian Best Practices Portal.**
www.cbpp-pcpe.phac-aspc.gc.ca/index-eng.html

3) **website: Canadian Centre for Occupational Health and Safety. Advancing Healthy Workplaces.**
www.ccohs.ca/healthyworkplaces

4) **website: WELCOA Wellness Council of America.**
www.welcoa.org

5) **website: The Guide to Community Preventive Service**
www.thecommunityguide.org/worksite/index.html

Specifically for physicians:

1) **website: ePhysicianHealth.com**.
www.ephysicianhealth.com

2) **website: International Alliance for Physician Health.**
www.cma.ca/index.cfm/ci_id/89721/la_id/1.htm

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Chapter 4

TAKING ACTION TO REDUCE SOCIAL INEQUALITIES IN HEALTH IN THE WORKPLACE

Key Points

Be aware that health promotion programs geared to the organization as a whole do not adequately meet the needs of all employees.

Always take into consideration the fact that a person's health can be influenced by factors related to membership in one particular category or group, including:

> Job title;
> Gender;
> Age;
> Ethnic or cultural community.

Create a profile of your institution in order to more precisely target any existing or potential social inequalities in health within the institution.

Make an effort to learn about the specific needs of employees, what their daily work experience is like, and how their workplace reality may be detrimental to their health.

Encourage the involvement of employees from different categories or groups in meeting objectives and developing activities offered by the institution.

Focus on actions aimed at minimizing existing social inequalities associated with belonging to certain employee subgroups. For example, create policies on work–life balance, make work areas ergonomic, and tailor health promotion programs to staff working on night shifts.

"Achieving health equity requires safe, secure, and fairly paid work, year-round work opportunities, and healthy work-life balance for all."

– *Closing the Gap in a Generation,* WHO, 2008[1]

What are social inequalities in health?

1

The Léa-Roback Research Centre on Social Inequalities in Health of Montreal was established in order to gain a better understanding of the impact of one's environment on physical and mental health. More specifically, its mission is to raise awareness about this relationship with the ultimate goal of reducing social inequalities in health in Montreal. The Léa-Roback Centre defines social inequalities in health as follows[2]:

> *"'Social inequalities in health' are those albeit avoidable disparities between men and women, between different socio-economic groups and between territories that have an impact on numerous aspects of the health of populations."*
>
> *The term 'health gradient' denotes a relationship between a person's position in the social hierarchy and his or her health status. In other words, 'people in higher socio-economic groups are in better health than those in the group on step below, and so on down the scale to the most vulnerable individuals.'*
>
> *'Social inequalities in health' also refer to any association between a person's health and his or her belonging to a particular social group. In Canada, social inequalities in health are particularly related to gender, being of Aboriginal origin, and education level."*

Social inequalities in health refer to the differences in access that various socially defined categories of people (e.g. by socio-economic status, gender, age, social position and ethnicity) have to resources and societal benefits such as: the labour market and other sources of income, education and health systems, and various forms of political representation and participation[3].

There are correlations between the various socio-economic/demographic factors and health status. Here are a few examples[1, 2, 3, 8]:

- "There is a clear correlation between the gross national product, income level, living standards and average life expectancy when nations are compared, but also notable differences between different socio-economic strata and occupational groups within nations."[8]. While health has improved somewhat over the years, flagrant inequalities in health persist;
- Numerous studies have documented the precarious health status of unemployed people, underemployed people over the long term (as a function of their skills, the number of hours they are able to work, etc.) and employed people who lack job security compared to employees with permanent status;
- People who have a higher social status are in better health;
- Work-related musculoskeletal disorders are generally associated with a lower socio-economic status.

To effectively fight against social inequalities in health, the WHO's Commission on Social Determinants of Health (2008) put forward the following recommendations:

- Improve daily living conditions;
- Tackle the inequitable distribution of power, money and resources;
- Measure and understand the problem and assess the impact of action.

2 Inequalities among healthcare workers

2.1 Inequalities and the workplace

The workplace can be seen as a collection of individuals who differ in age, gender and hierarchical position and who belong to a variety of social and ethnic groups. As such, the workplace itself can be an environment that contributes to disparities among certain categories of people or reinforces social inequalities in health where awareness and/or corrective action to counter such disparities are not present.

As previously mentioned, evidence has shown that the principal determinants of health are economic and social. Nonetheless, few studies exist on initiatives aimed at reducing disparities.

In her review of the international literature entitled *Quelles interventions pour lutter contre les inégalités sociales de santé?*[5] [What measures exist to fight against social inequalities in health?], Ridde demonstrated that evaluations of global health promotion interventions are flawed, and it is consequently difficult to measure their effectiveness. Some authors argue that health promotion interventions that do not set objectives to reduce disparities can actually exacerbate them, although this is not a consistent finding among all researchers. But one conclusion is undeniable: beyond implementing global initiatives, it is becoming increasingly important to take actions targeting specific disadvantaged groups. In her literature review, Ridde concludes that action must be taken on all fronts with as many target groups as possible, using an Intersectoral approach.

Working conditions explain health inequalities to a large extent, particularly with respect to coronary diseases, mental health and musculoskeletal disorders. As such, the workplace represents an ideal setting in which to take action to reduce these inequalities.

And according to Ridde, employers are generally more inclined to want to improve the health status of their employees in order to ensure that quality and productivity objectives are met than for the purpose of reducing inequalities among employees.

2.2 How does this relate to healthcare workers?

At first glance, one might doubt the existence of flagrant inequalities among workers in the health sector, since most of these jobs are government jobs, which generally entail good working conditions in terms of pay and benefits compared with many other sectors.

However, upon closer examination, one notices that the way in which employees are categorized can create differential impacts on their health. These categories are notably: gender, work categories that expose employees to greater risk than others, age, immigrant status and ethnicity or cultural community.

Snapshot of a workforce

Example: Montreal, Quebec, Canada[6]

> 85,000 people are employed by the health system in Montreal;
> 76% of the aggregate workforce is made up of women;
> Certain jobs are predominantly occupied by women, such as:
  - Audiologists and speech language pathologists (94%);
  - Occupational therapists (92%);
  - Nurses (91%);
  - Physiotherapists (84%).
> Some of these jobs have a significant "maternity" factor, given the high percentage of women aged 39 or younger;
> Close to half (48%) of health system personnel hold full-time jobs;
> 75% of workers hold a permanent position;
> The aging of the system's workforce is particularly evidenced by the increase in the group aged 50 years and over: from 21% in 1999 to 33.12% in 2009;
> Certain job titles comprise a high percentage of employees aged 50 or over: electricians/plumbers; caregivers and executive secretaries; nursing assistants; social workers; registered nurses.

The health status of healthcare workers: a global perspective[7]

> Significant prevalence of chronic diseases among health care professionals;
> High prevalence of unhealthy lifestyle behaviours;
> High levels of occupational stress;
> Impaired health-related quality of life;
> Moderate compliance to secondary prevention guidelines;
> Evident inequalities between staff categories, between and within countries.

2.3 Taking action to reduce inequalities and improve employee health

In order to improve health in the workplace, employers must be made aware of the fact that belonging to one particular subgroup or another impacts the health of their employees. For example, employees aged 50 or over, employees who are parents of young children, and employees whose positions expose them to greater risk of injury have specific needs that the organization must take into account in order to eradicate or mitigate the known risks and ultimately create a better work environment.

However, questions remain about the extent to which healthcare organizations are concerned about these inequalities. The trend noted in health promotion programs is that they generally address staff as a whole and do not take into account the specific needs of particular employee subgroups.

Organizations tend to opt for healthy lifestyle programs that are geared to their overall workforce. However, if healthcare organizations became informed about the role they can play and the possible actions available to them, they could help reduce social inequalities in health among their own population of workers.

2

The starting point for action: be aware!

1. Questions that organizations should ask themselves before getting started:
   - > Who are these employees and what are their particular needs/concerns?
   - > What do these workers experience on a daily basis?
   - > How can this work reality affect their health?
2. What can we as an organization do to improve and maintain the health of employees?
3. Your objectives:
   - > Identify the existing and potential social inequalities in health within your organization;
   - > Target feasible interventions to minimize the existing inequalities;
   - > Encourage the various categories of workers to become actively involved in the objectives and activities proposed by the organization.

Create a profile of your organization

Objective: Take note of the composition of your workforce as well as the disparities between the different categories of personnel in order to adapt your management practices, health promotion strategies and occupational health and safety measures.

- > Occupations
  - • Managers
  - • Professionals
  - • Technicians
  - • Support staff
  - • Physicians
  - • Others
- > Gender
  - • Men
  - • Women
- > Work categories by age[a]
- > Permanent job rate
- > Income
- > Cultural minorities

The next sections present the health effects associated with the following employee subgroups: job title, age, gender, and ethnic or cultural community. These sections also contain recommendations aimed at reducing disparities between employee groups.

3

Impact of job title

"Esteem and social approval depend largely on one's type of job, professional training and level of occupational achievement. Furthermore, type and quality of occupation, especially the degree of self-direction at work, strongly influence personal attitudes and behavioural patterns in areas not directly related to work, such as leisure, family life, education and political activity"[8]. To a certain extent, a person's salary may also impact job satisfaction and, by extension, his or her health.

a The workforce in developed countries is currently aging, and for the first time there are more workers aged 55 to 64 than 20 to 26.

3.1 Psychosocial conditions and stress

"It is generally acknowledged that [less favourable working] conditions have always affected lower socio-economic groups more than the higher. The lower the occupational class, for example, the more likely are people to experience low decision latitude and the less reward they are likely to get."[8]. European studies have shown that being unable to exercise one's skills and having only limited power over decisions at work are detrimental to one's health[9].

A psychosocial work environment that is excessively demanding of employees, offers only limited self-determination over tasks, and does not provide adequate support limits workers' effectiveness and creates stress. Over the long term, stress can lead to such health problems as depression, anxiety[10] and coronary disease[11]. Nurses are particularly impacted by stress. They are constantly confronted with new and unpredictable situations that require urgent action[12]. The World Health Organization (WHO) predicts that in 2020, depression linked to stress will be the second leading cause of disability worldwide, after cardiovascular incidents.

Furthermore, employees who don't enjoy positive psychosocial conditions in the workplace may provide poorer quality of care to patients. For example, the heightened needs of inpatients, lengthy overtime hours, and the need to perform multiple roles are all factors that can contribute to a higher rate of incident reports and negative treatment outcomes[13].

Managers and professionals feel much more overworked compared to other employees, due to long work hours. This can exacerbate the struggle to balance work and family life. More specifically, women who are professionals or "senior managers" are less satisfied with their work–family balance than are unskilled workers; a large proportion of them (40%) report having insufficient time to fulfill all of their responsibilities[14].

TAKE ACTION

- **Improve and ensure early detection of psychological health problems at work;**
- **Develop stress prevention programs;**
- **Develop measures to better support managers in the execution of their jobs;**
- **Modify the organizational work models for certain employee groups:**
  - **Participation in the decision making process;**
  - **Adequate recognition;**
- **Create work–life balance programs adapted to evening and night shift workers:**
  - **Flexible schedules;**
  - **Creation of permanent part-time positions.**

Project

***Workplace Improvement Committee* – CSSS de Bordeaux-Cartierville-Saint-Laurent – Montreal, Canada**

This CSSS decided to initiate an extensive consultation exercise in order to identify the main actions that would enable the centre to achieve the title of "employer-of-choice" within two to three years. A panel was formed specifically for the organization's managers to address the specific needs of this group in four areas: working conditions, attraction and retention, professional development and recognition. It identified three objectives:

Support managers in the performance of their roles and promote work–life balance.

Support managers to improve effectiveness in the challenges involved in integrating services, quality and performance.

Create some leeway in order to support managers in the performance of their roles.

(See Project Description Nº 1)

3 3.2 Musculoskeletal disorders (MSDs)

"Approximately 30–40% of musculoskeletal disorders are considered to be work-related in the Nordic countries"[8]. Risk factors include:

> Working in painful positions (e.g. standing);
> Moving heavy loads;
> Performing short, repetitive tasks and repetitive movements.

Organizational and psychosocial factors also influence the occurrence of MSDs. The social culture of the workplace, group pressure, negative relations with colleagues, and role ambiguity can all contribute to the development of MSDs[15].

"High rates of work-related injuries are seen among healthcare workers involved in lifting and transferring patients"[8]. Nurses, nurse assistants and orderlies are thus among the most at-risk. "Interventions that attempt to involve the entire organization... in a continuous effort to improve health by reducing identified risk factors, are more often successful"[8].

Project

***Preventing Musculoskeletal Disorders in Nursing Staff and Caregivers* – East Tallinn Central Hospital – Tallinn, Estonia**

The aim of this project was to create a safe working environment for the staff responsible for caring for and assisting inpatients. The case describes the process undertaken to arrive at correct patient handling techniques in order to prevent MSDs. It included a risk-analysis of the work environment and employee training on safe work practices. In order to create a safer work environment, the hospital's administration invested in infrastructures, which notably included renovations to the facilities. These actions fostered a greater awareness among employers of the importance of workers' rights in terms of health and safety at work.

(See Project Description Nº 17)

TAKE ACTION

> **Promote interventions that involve the entire organization (include both staff and management);**
> **Promote the ergonomic design of work spaces and employee training on safe work practices.**

Inspiring initiative

Participatory Ergonomic Teams for Hospital Orderlies – Norway[8]

"These teams, formed of three orderlies (one supervisor and two technical advisors), designed and implemented changes in training and work practices in a 1200-bed urban hospital. Team members were responsible for identifying and prioritizing safety issues as well as evaluating and implementing solutions... Two major factors contributing to injury were identified: the lack of standard procedures for lifting and moving patients, and inconsistent training procedures for employees... By the end of the two-year intervention period, the risks of injury were reduced by around 60%, lost work time decreased by 75%, and annual workers' compensation costs declined markedly. Moreover, there were significant improvements in job satisfaction, perceived psychosocial stressors and social support among the orderlies."[b]

b Citations taken from Hogstedt and Lundberg (2002), *Work-Related Policies and Intervention*.

3.3 Shift work: late shifts and rotations

As in other sectors, the health and social service system schedules shift work.

A number of detrimental health effects are associated with working evening and night shifts as well as rotation schedules. Indeed, several studies have revealed the harmful effects that night shift work can have on employee health and productivity. In particular, workers on these shifts are susceptible to developing problems in the following areas[16, 17, 18]:

1. Physical health, such as sleeping and gastro-intestinal problems, obesity, hypertension and cancer;
2. Mental health;
3. Social isolation and marginalization, affecting family and social activities.

Sleep deprivation engendered by a night shift schedule is also at the root of many workplace accidents.

Night shift work has been found to affect women's health in particular, through its disruption of the menstrual cycle and causal links to breast cancer.

It is difficult for night shift workers to have access to healthy lifestyle programs because of the particularity of their schedules, which is largely out of sync with resources such as fitness centres and classes, health workshops, and smoking cessation programs.

SUGGESTED WEBSITE

Nutrition Tips for Shift Workers

Eat Right Ontario

This online article explains that maintaining healthy eating habits is a challenge, particularly for night shift workers, for whom the only available food often comes from vending machines or fast food outlets. Nonetheless, good nutrition is essential to coping with the types of problems that come with this work schedule. This website provides practical suggestions to facilitate healthy eating.

www.eatrightontario.ca/en/ViewDocument.aspx?id=23

TAKE ACTION

Make changes at the employee level:

> **Develop a program promoting health and wellness at work that is tailored to night shift workers: tips on nutrition, sleep, work–life balance, socializing and physical activity.**

Make changes at the institutional or organizational level:

> **Make changes to the physical work environment to make shift work easier on employees (access to healthy meals and childcare services, proper ventilation and lighting systems).**

4 Impact of gender

4.1 Occupational status and income level

Within the health field, women are overrepresented in caregiving roles and part-time work, "resulting in significant gender differences in terms of employment security, promotion, and remuneration."[19]

There is a higher incidence of workplace accidents among temporary workers, the majority of whom are women[20].

The occupations women hold are often associated with gender stereotypes.

4.2 Work–life balance

Different situations for men and women

Women are often the primary caregivers of their children and other family members. Tremblay[14] found a significant difference in the percentage of family responsibilities assumed by partners, where men took on an average of 39% of responsibilities, and women assumed 55% of the responsibilities.

According to Tremblay (2004), "women more often refuse work-related responsibilities because of their family obligations" (28% vs. 18% for men). "Women are more willing to agree to a voluntary reduction in work time" (58% vs. 50%), and it is more common for women than men to make adjustments to their work schedules. For example, "type of work contract, work schedule, use of breaks to catch up with family tasks, and transportation of children are all phenomena that are gender-differentiated. [...] It is also more common for women to consider work–family balance problems as a reason to leave their job, and they have less leeway than men in organizing their work." Compared to women, "men work more often outside regular hours as part of a team in the evening, at night or on Saturday" and are therefore less available for family activities and responsibilities (Tremblay, 2004). These types of issues are more prevalent in women and men aged 36–45 than those aged 35 or under.

In hospitals, the stress caused by instability related to the restructuring of the healthcare system, coupled with weighty domestic responsibilities, contributed to health problems among nursing staff[20].

Stressors

The majority of researchers support the view that, in addition to family and personal factors, work-related factors play a significant role in stress. Such factors may include work schedules, hours of work, and workplace culture (e.g. attitudes of senior managers and supervisors, presence or absence of policies related to work–family balance).

Role conflicts

Role conflicts may become evident in the following situations:

> When the total time and energy required to accomplish the tasks involved in a person's various roles is too great to allow the person to perform the roles adequately or comfortably;
> When work demands and responsibilities make it difficult to fulfill family responsibilities and obligations, or vice versa;
> When, in addition to work, an employee has the added responsibilities of caring for a family member who is ill.

Project

***Organizational Well-Being and Instruments for Reconciling Work and Family* – Health Services Regional Agency – Trento, Italy**

"Organizational well-being and instruments for reconciling work and family" are measures aimed at fostering a balance between work and family obligations: childcare services (with extended hours), personalized work schedules and telecommuting.

(See Project Description Nº 26)

TAKE ACTION

Adopt policies or standards to manage the work–life balance. Such policies help ensure gender-equitable integration in the workforce. They encourage and recognize the value of equal participation in parental responsibilities and challenge preconceived notions about gender roles.

Policies and standards of this kind include:

> **Reorganization of work time (flexible hours, adapted schedules, reduction in work time);**
> **Flexibility in the work location when possible;**
> **Services offered at the workplace (personnel or financial support, on-site daycare, emergency daycare assistance, etc.);**
> **Benefits program that can extend to family members;**
> **Increased support from supervisors and colleagues;**
> **Establishment of links with community resources.**

Source: Bureau de normalisation du Québec [BNQ]. (2010). *Standard 9700-820, Work–Family Balance*, June 30, 2010.

4 4.3 Violence and harassment

A gender-based analysis of the workforce has uncovered significant levels of violence experienced by healthcare workers. Women are far more likely to be victims of violence at the hands of patients[21].

In June 2004, Quebec's *Act Respecting Labour Standards* added a provision requiring employers to take the necessary action to prevent psychological harassment in the workplace. In practice, we note that grievances are often classified as acts of incivility. This term encompasses rudeness, meanness, vulgarity, acts of disrespect, and lack of manners.

TAKE ACTION

- **Adopt measures to counter workplace violence and harassment, and sensitize and educate employees about these issues;**
- **Adopt a workplace civility policy.**

Project

***Fostering a Respectful Workplace and Preventing Violence* – Chatham-Kent Health Alliance – Ontario, Canada**

A Workplace Violence Prevention Steering Committee was established to address management issues pertaining to the prevention of violence in the workplace.

A Code of Conduct Policy was revised based on a literature review, legal counsel and staff input. The policy was studied and approved by the Medical Advisory Committee, the Mission and Quality Committee, and the board of directors.

The policy was distributed and communicated to staff through Code of Conduct information sessions. Other related policies have since been created and revised: Anti-Harassment and Discrimination Policy; Code of Conduct; Violence: Management in the Workplace; and the Domestic Violence Policy.

(See Project Description Nº 13)

Inspiring initiative

***Training Program on Harassment and Civility in the Workplace* – Quebec Association of Healthcare Institutions (AQESSS) – Quebec, Canada**

Since 2004, approximately 5,000 of the 11,000 managers that work in the AQESSS member facilities have received training in harassment management and civility standards. These training programs have enabled managers to intervene with confidence and in a straightforward manner in situations where the concept of harassment is not always clear. They have also educated managers about the etiquette that should be practised by everyone in order to prevent situations of incivility. Furthermore, the programs have equipped managers to act effectively in the event of work team conflicts and in general move toward a more harmonious workplace climate.

Impact of age

5

5.1 The aging of the workforce and its impacts on the healthcare system

To date, few studies have looked at the impact of the aging workforce on health and social services. This may be explained by the fact that, for the first time in history, there are more healthcare workers in the 55–64 age group than in the 20–26 age group. This points to a marked percentage of employees who will be retiring from the workforce.

This is an important issue, because not only do employers want to keep their most skilled and experienced employees from retiring, they also want to prevent them from moving to other companies. For example, 33% of this aging workforce would agree to postpone their retirement if incentives to continue working were offered[22].

The caregiver challenge

At a time when the healthcare workforce is aging, these employees are also faced with the stress of having to care for elderly members of their own families, their spouses, children, grandparents, grandchildren, extended family members and sometimes even their colleagues. In the future, an increasing number of employees will become involved in this type of caregiving.

According to a 2002 Statistics Canada report[23], over 1.7 million adults aged 45–64 care for an elderly person with a long-term disability or limited mobility. Among the caregivers in this study, 70% were employed, and 30% of these individuals reported serious constraints placed on them by the care they provide to an elderly person.

TAKE ACTION

Reduce stressors by instituting work–life balance measures

A work–life balance policy must include:

- **A reorganization of work time (flexible hours and leaves of absence);**
- **Flexibility of work location when possible;**
- **Services or goods offered on site (financial support);**
- **Personnel support;**
- **Benefits programs that can extend to senior family members.**

Source: Bureau de normalisation du Québec (BNQ). (2010). *Standard 9700-820, Work–Family Balance,* June 30, 2010.

Adapt working conditions:

- **Support flexible work organization and autonomy;**
- **Adapt the physical workload to minimize the negative effects on health.**

Address existing retirement disincentives:

- **Provide financial incentive instruments;**
- **Improve health insurance coverage.**

In the same report, employees aged 45–64 (mostly women) who were caring for an elderly person requested an adjustment to their work schedule. Twenty-seven per cent of the women and 16% of the men modified their work schedule (e.g. arrived later or left earlier), others reduced their work hours, turned down promotions or even left their jobs altogether.

One out of five women and one out of 10 men stated that the level of care they needed to provide was their main reason for taking retirement[23].

What can be done to retain older personnel and adapt management practices

In her article entitled *Intervention designed to increase retention of older workers: a review of current knowledge*[c], author D. Berthelette[24] made the following observations:

> Few new human resource practices have been established in organizations to retain their aging workforce;
> When such measures are in place, their effectiveness is rarely assessed scientifically to determine their effectiveness;
> There is little scientific knowledge about the motivating factors involved in decisions to remain in the workforce or take retirement.

In this article, the author cites Robson et al., who proposed five criteria to evaluate the extent to which employees age well in their workplace environment:

> Ability to adapt to changes and maintain one's physical, psychological, and cognitive health;
> Presence of positive relationships in the workplace;
> Opportunity to continue to develop professionally and remain competitive;
> Perceived job security;
> Continuous setting and achievement of objectives.

While the above criteria are just as important to workers in other age categories, it would not be unreasonable to assume that measures characterized by flexibility and a higher level of social security would bolster the retention of older personnel.

Inspiring initiatives

Australia has implemented a vacation purchase program[25]:

> Employees can purchase between one and four weeks of additional vacation time;
> Possibility of working six months of the year.

In Jamaica, nurses take their retirement at age 60 but can then work as seasonal employees[25].

c Translator's note: This is an unofficial translation of the original French title of this article.

5.2 Multi-generational work teams

In developed countries, at least four generations currently coexist in the labour force. This diversity entails certain challenges, as each generation is characterized by a particular set of beliefs, values and preferences[25].

The nursing workforce is currently composed of four generations of employees: veterans, baby boomers, generation X and generation Y. Certain differences in values exist between these groups, and they each have their strengths and weaknesses.

Nonetheless, multi-generational teams allow for a combination of skill levels and experience. They provide an opportunity for the younger workers to learn through the training and mentorship provided by their senior colleagues. As such, the expertise and knowledge of the senior staff members can be used to break down age-related prejudices.

Inspiring initiative

Mentorship Program **– Montreal University Hospital Centre – Montreal, Canada**

A mentorship program was established in 2003 to support the next generation of nurses and allow the senior staff to share their expertise. Mentorship is a relationship founded on mutual respect between an experienced, recognized and credible employee and an employee at the beginning of his or her career.

There is also preceptorship, an integration program that provides a means for newly trained nurses to advance in learning their professional roles and facilitates their socialization. It is implemented with the collaboration of experienced nursing staff.

TAKE ACTION

Adapt management practices[25]

Take action in:

> Work relations (interpersonal conflict resolution, transfer of information, communication skills);
> Usefulness of work;
> Skills development (coaching, preceptorships, mentorships);
> Autonomy (involvement in decisions);
> Recognizing and rewarding accomplishments.

Be flexible and adaptable

Prevent and manage intergenerational conflicts and take into account the generational differences in various areas: recruiting, orientation, training, motivation and coaching.

6 Impact of immigration and being part of a cultural minority

"The systematic management of diversity and the achievement of equal opportunity are necessities, not only from a humanitarian and human rights perspective, but also because they are key to enabling a healthcare organization to takes its place on the global stage."[d]

– Source: Saladin, P. (2009). *Swiss network of hospitals for the migrant population*, Migrant-Friendly Hospitals, "Rendez-vous interculturel", Montreal, September 29, 2009.

6.1 Immigration and cultural diversity

Cultural diversity is a prominent feature of many large European and North American cities. It must therefore be reflected in the various spheres of society, including the workforces of healthcare institutions.

Studies indicate that, despite their generally high level of education, a significant number of newly and recently arrived immigrants (less than five years) are unemployed. Research has also shown that, over time, the gap shrinks and the rate of employment improves. Frequently cited obstacles include: lack of work experience in the receiving country, language barriers, and problems regarding the recognition of foreign credentials.

Once these individuals are integrated into the labour force, certain challenges with respect to the management of cultural diversity can surface and lead to social inequalities in health.

In Canada and other countries, government action has been taken to fight inequalities, discrimination, and prejudices affecting immigrants, particularly members of visible minorities. Among other objectives, a notable goal of these initiatives is to increase the representation of people from diverse cultural backgrounds in public administration.

A few facts

In Switzerland

> In 2004, foreign residents represented 21.8% of the population;
> In certain major healthcare institutions, the immigrant population and Swiss citizens of migrant backgrounds represent up to 80% of the workforce;
> The vast majority of the immigrant population is of European origin. However, a growing cultural diversification has been observed in the past several years;
> In 2004, 14.6% of the immigrant population were from non-European countries.

Source: Swiss Federal Office of Public Health, 2009.

d Translator's note: this is a loose translation from French of the original quotation.

In Montreal, Canada

> The population of the administrative region of Montreal is 1,823,000;
> Immigrants constitute 30% of Montreal's population;
> One-third of the immigrant population have neither French nor English as their mother tongue;
> 135,585 new immigrants arrived between 2001 and 2006, and there are 37,535 non-permanent residents; (*2006 Census)*;
> 40,000 immigrants per year move to Montreal, and 75% of the group aged 16 years or older are seeking to enter the labour force (Immigration Québec, 2009);
> Upon their arrival, 3–4% of immigrants declare an occupation related to the health sector.

Source: Pierre Laflamme, Ministry of Health and Social Services, Quebec, September, 2009.

6.2 Integrating into the labour force

While some immigrants integrate quickly and without too much difficulty, others encounter many obstacles. One of the significant barriers experienced by new immigrants is the recognition of their foreign credentials, and this phenomenon is especially observed in fields with a shortage of workers. Ironically, it is often in an attempt to fill these shortages that a number of healthcare and social services organizations turn to the immigrant workforce.

Over-qualification of the immigrant workforce and difficulties integrating into the labour force are well-known and documented phenomena.

Female immigrants are confronted with even greater challenges integrating into the labour force than their male counterparts. They are overrepresented in healthcare and social services as well as other service sectors, and their job security is often precarious. Female immigrants experience the compounded issues of women's employment equity as well as that of recognition of their skills[26].

TAKE ACTION

Create an equal access to employment program that would allow for:

> **An analysis of the employment system, in particular the recruitment, training and promotion policies and practices;**
> **Equal opportunity and support measures as needed to eradicate discriminatory management practices.**

In Quebec, Canada

The ***Act Respecting Equal Access to Employment in Public Bodies*** seeks to render the personnel of these organizations more representative of the available workforce and to remedy practices in the employment system that can have exclusionary effects. The Act applies to bodies that employ 100 people or more in various sectors, including healthcare and social services.

The groups targeted by the Act were determined on the basis of socio-economic indicators that confirmed a history of discrimination that persists today. Included among these groups are members of visible and ethnic minorities.

Public organizations are required to conduct an analysis of their workforce to determine the number of employees belonging to each of the groups targeted by the Act. They must also produce a report of the workforce analysis and subsequently establish an equal access to employment program.

6 6.3 Managing cultural diversity

While the growing presence of visible and cultural minorities in the workplace—and in society generally—creates a more technically and culturally enriched environment, it can also create certain challenges in managing the workforce and human relations in the workplace. Given this reality, a number of actions have been proposed to help properly manage workplace diversity, while emphasizing the importance of welcoming and retaining people from diverse backgrounds. However, institutions must identify areas in which it is not possible to take individual cultural needs into account.

Diversity is "a value-neutral description of personal and social differences which are an innate feature of modern societies and which have their origin *inter alia* in a person's background, gender, language, skills, age, lifestyle and social status."[27]

TAKE ACTION

- **Establish a diversity management program specifically aimed at creating an inclusive work environment, free from discrimination;**
- **Improve the intercultural education of personnel;**
- **Revise management practices to ensure not only equal access to employment, but work stability and opportunities for promotion.**

SUGGESTED READINGS AND WEBSITES

Diversity and Equality of Opportunity: Fundamentals for Effective Action in the Microcosm of the Health Institution Handbook
With DVD ***Comprehension Can Cure***
A publication of the Swiss Federal Office of Public Health in collaboration with H+ Switzerland's Hospitals. This purpose of this handbook is to support healthcare institutions in their search for a valid and effective response to the phenomena of diversity and migration. The main body of the manual comprises a set of recommendations addressed to the administrators of healthcare institutions, so that they might revise their institutions' policies from the perspective of diversity and migration and develop appropriate measures. Such measures address patients and families as well as healthcare workers. A free download of this handbook is available at:
www.bag.admin.ch/shop/00038/00209/index.html?lang=en

The Amsterdam Declaration Toward Migrant-Friendly Hospitals in an Ethno-Culturally Diverse Europe
"The document starts with a summary analysis of the current situation of hospital services for migrants and ethnic minorities in Europe, highlighting quality-related problems for patients and staff. It assumes that improving quality for migrants and ethnic minorities as specific vulnerable groups would also serve the general interest of all patients in more personalised services. This is an issue high on the agenda of the Health Promoting Hospital network. Improvements could be achieved for all by making hospitals more responsive to ethnic, cultural and other social differences of patients and staff. In the second part of the Amsterdam Declaration, recommendations are made for specific contributions to quality improvement by hospital management and staff, by health policy, by patient organisations and the health sciences. [...]

The declaration has been endorsed by a large number of European and international organisations, representatives of which presented their perspectives on the Amsterdam Declaration at the conference. Partners expressed their expectation that the Amsterdam Declaration will serve as a European platform for improving hospital and health care services for migrants and ethnic minorities."

The final text is available in 11 languages: www.mfh-eu.net

The Task Force on Migrant-Friendly and Culturally Competent Healthcare
www.ausl.re.it/HPH/FrontEnd/Home/Default.aspx?channel_id=38

"The Task Force was set up to continue the momentum created by the MFH project which involved 12 European countries engaged in the development of models of good practice for promoting health and health literacy of migrants and improving hospital services for these patient groups in selected pilot hospitals."

The Swiss Network of Health Promoting Hospitals and Health Services
www.healthhospitals.ch

A section of this website is dedicated to migrant-friendly hospitals (MFHs). It is possible to download a French version of the manual, "Diversity and Equality of Opportunity," mentioned above.

Projects

***Healthy Work Without Barriers* – Women's Health Centre FEM Sud – Vienna, Austria**
This healthy workplace promotion program, which is focused on the particular needs of immigrant women, was implemented in six hospitals in Vienna. More specifically, it targets the multicultural female hospital cleaning staff, which is a group characterized by low socio-economic status and low education levels. The aim of this project was to increase job satisfaction and empowerment within this group, as well as improving their physical, mental and social health.

(See Project Description Nº 27)

***Creative Recruiting of New Client Care Attendants* – Canadian-Polish Welfare Institute Inc. – Montreal, Canada**
This long-term care centre (CHSLD) serving Montreal's Polish and Slavic communities needed to find a creative solution to recruiting new employees. Given the availability of a workforce of newly immigrated people of Slavic origin who did not have the financial means to attend courses, the Centre's administration decided to offer these individuals client care attendant training, free of charge.

(See Project Description Nº 28)

FIND OUT MORE

Commission on Social Determinants of Health – Final Report
Closing the gap in a generation: Health equity through action on the social determinants of health. World Health Organization, 2008.

Social inequalities in health are a function of the circumstances in which people grow, live, work and age, as well as the systems in place to treat illness. Moreover, the conditions in which people live and die are determined by political, social and economic forces. To mitigate these circumstances, national governments, the WHO, specialized organizations of the United Nations and civil society organizations must take concerted action by appealing to all sectors. An improvement in equitable access to health must be an objective shared by all.

www.who.int/social_determinants/en

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Chapter 5

INTEGRATING SUSTAINABLE DEVELOPMENT: MAKING CHOICES THAT PROTECT THE ENVIRONMENT

Key Points

- Adopt a sustainable development policy and communicate the institution's sustainable development objectives to employees and partners.
- Equip each building with a functional waste management system.
- Reduce water consumption in all buildings.
- Incorporate sustainable development principles into all facility construction or renovation projects from their earliest stages.
- Adopt a green procurement policy.
- Encourage sustainable transportation (carpooling, public transit, active transportation) for professional travel and employee commuting.
- Conduct an audit of energy consumption in all buildings.

"The foundation of human health rests on healthy, stable ecosystems."

– Pierce, Jameton, 2004[1]

1 Introduction

Over the past several decades, the pressures exerted on the world's ecosystems as a result of human activity have been felt all across the globe. The science is telling us that the coming years will be critical if we are to avoid catastrophic climate change and the decline in worldwide human health that would result from the continued deterioration in our environment.

Despite advances in both medical and engineering science in the 19th and 20th centuries and the significant improvements in public health that gave rise to the establishment of such practices as water purification, social hygiene and vaccinations, the health of most of the world's population remains far from secure. The trends leading to environmental degradation have long been in evidence, and while some of them have been reversed on a national scale, none has been reversed on a global scale[2].

Profound changes need to be made by all social stakeholders if we want to halt the degradation of the biological systems that support health. As a major actor representing approximately 10% of the country's economy, the Canadian healthcare system itself contributes significantly to morbidity and mortality caused by environmental pollution[3].

Given that the healthcare sector is among the largest employers in most countries (employing over 35,000 in Quebec, Canada in 2008[4]; and one out of 10 Europeans[5]), and since substantial financial investment is required to operate this sector[6], the healthcare system has a role to play in reducing negative impacts on the environment. Moreover, as stewards of human health, healthcare institutions have a duty to set an example to the population and to educate them about the potential harm their actions may be causing to their own health and that of their loved ones. In fact, "leading by example" is one of the 10 essential measures recommended by the World Health Organization to healthcare workers for the protection of health from the harmful effects of climate change[7].

1

According to the WHO, healthcare institutions can play a leadership role in mitigating the effects of climate change[8]. Therefore, at its 2010 annual convention, the Network of Health Promoting Hospitals decided to establish a working group on the environment. The goals of this new entity are threefold: first, to define the criteria for determining whether a healthcare institution or service is environmentally responsible; secondly, to create evidence-based policies and intervention programs; and thirdly, to promote health in an environmentally responsible way.

Definitions

2

Sustainable development: development that meets the needs of the present without compromising the ability of future generations to meet their own needs. Sustainable development is a long-term approach that takes into account the inextricable links between the environmental, social and economic dimensions of development activities[9].

Waste matter: any solid or liquid residue of a process of production, conversion or use, or any material, substance or product that has been abandoned or that the possessor intends to discard[10].

Ultimate waste: expired, discarded or otherwise rejected matter or object, the salvageability or potential value of which is nonexistent given the availability and economic viability of the current processing technologies[10].

Composting: a biochemical method of waste treatment that uses the action of aerobic microorganisms to decompose biodegradable materials at an accelerated rate for the purpose of obtaining an organic material called compost[10].

Compostable material: organic or inorganic matter that can be broken down through the process of composting. Examples include biodegradable waste and paper[10].

Biodegradable waste: matter, typically organic, that is capable of being decomposed by microorganisms[10].

Recyclable materials: secondary materials that can be used in the manufacturing process as a substitute for virgin materials[10].

Biomedical waste: the *Regulation Respecting Biomedical Waste* defines this type of waste as[11]:

> Human anatomical waste consisting of body parts or organs, but excluding teeth, hair, nails, blood, and biological liquids;
> Animal anatomical waste consisting of carcasses, body parts or organs, but excluding teeth, hair, claws, feathers, blood, and biological liquids;
> Non-anatomical waste consisting of any of the following:
  - A sharp or breakable object that has been in contact with blood or with a biological liquid or tissue and has been used in medical, dental or veterinary care or in a medical or veterinary biology laboratory, or such an object used in thanatopraxy;

2

- Biological tissue, cell cultures, microbial cultures, or material in contact with such tissue or cultures, used in a medical or veterinary biology laboratory;
- Live vaccine;
- A blood container or material that has been saturated with blood and used in medical care, in a medical biology laboratory or in thanatopraxy.

Renewable energy: Energy whose source is renewed or regenerated naturally and is available in very large quantities relative to the needs of humanity. Solar radiation, hydraulic power, geothermal energy, and wind are examples of renewable energies.

It should be noted that even if a form of energy is considered renewable, it cannot be exploited at a rate that exceeds the quantities recaptured or generated[12].

Geothermal energy: thermal energy contained in water or water vapour and coming from molten rock deep beneath the Earth's surface[12]. In a geothermal system, a fluid circulates through subterranean pipes, where it absorbs heat from the surrounding groundwater or soil. The longer or more extensive the fluid's piping system, the more heat it can absorb. Once the heated fluid returns to the compressor, the heat is extracted and transferred to a heat pump. The pump heats the air, which is then distributed throughout the building. In summer, the compressor transfers heat from the building to the fluid in the loop. The fluid dissipates the heat into the soil and, once cooled, the fluid returns to the building[13].

3 Waste management

Solid waste represents the largest proportion of potential healthcare industry pollution[14]. A 1998 study by Health Care Without Harm estimated that a single hospital generates up to 7 kg of waste per bed per day. According to the study, there are four main reasons for this: excessive use of disposable plastics, improper use of biomedical waste receptacles, inefficient waste management, and lack of sufficient waste storage space[3].

In Canada, the health sector generates 1% of the country's solid waste[3], which in the province of Quebec represents approximately 98,000 metric tonnes of waste annually[15]. Studies show that biomedical waste accounts for approximately 10–15% of all hospital waste in the US, and for 25% of hospital waste in Europe[14].

Did you know...

The healthcare system by numbers:

> A single hospital produces 7 kg of waste per bed per day[3];
> 20–30% of hospital waste is generated in the operating room[16];
> The ecological footprint of the Lions Gate Hospital (Vancouver, Canada) is estimated to be 719 times the land area of its actual buildings[17].

The concept of recycling has now become an accepted part of people's lifestyles all over the world. So why is it such a challenge to create a functional waste management system in the workplace? Sound waste management encompasses all manner of waste materials generated by a healthcare facility: biomedical waste, recyclable or compostable waste, chemical products, and other materials. Proper waste management requires as much commitment from the organization as it does from each individual employee. To make it work, it is important to establish a communication system that is adapted to the setting. The healthcare system uses large quantities of toxic substances, which must therefore be disposed of in a secure manner.

Not only can poor or incomplete waste management lead to employee injuries (e.g. needlestick injuries), it can also lead to hygiene problems (e.g. inadequately rinsed containers that attract germs).

Waste management systems can differ quite substantially from one healthcare institution to another. Depending on its location, the costs of this service varies, as does the space needed to store waste between collections.

Nevertheless, below is a list of basic elements that should comprise an institutional waste management system, regardless of its location:

1. Collection of biomedical waste;
2. Collection of all other forms of waste (ultimate waste);
3. Recycling of paper, cardboard, plastics, glass and metal;
4. Recycling of biodegradable waste (e.g. food waste, paper towels);
5. Recycling of used batteries;
6. Recycling of printer cartridges;
7. Recycling of hazardous materials (e.g. compact fluorescent light bulbs, mercury, formaldehyde, etc.).

Did you know that...

In the US, economic concerns are driving an increasing number of healthcare facilities to turn to "reprocessed" products, which can translate into a 50% cost savings when compared with the cost of new medical equipment. In 2008, a 20% increase in the use of reprocessed materials was observed in the US, representing a cost savings of US$138 million and a total of 2,150 tonnes of waste diverted from landfill[18].

TAKE ACTION

1. Involve the employees who are responsible for waste management; they are your experts!
2. Conduct an audit of the waste materials generated by your institution and report on the estimated quantities of reusable materials;
3. Implement an integrated waste management system by clearly identifying, through the use of images, the materials appropriate for each receptacle;
4. Set yourself objectives with target figures (e.g. recycling rate to attain);
5. Remember to communicate the results to employees on an annual basis.

Projects

***Waste Management* – Philippine Heart Center, Philippine Children's Medical Center, San Lazaro Hospital – Manila, The Philippines**

Since incineration was prohibited in 1999, healthcare institutions in the Philippines have had to find alternative ways to manage their waste materials. Three hospitals in the Manila area were the subject of a 2007 study by Health Care Without Harm. The implementation of a recycling and composting program resulted in cost savings at all three hospitals. Furthermore, improvements in biomedical waste management led to a reduction in the amount of infectious waste produced.

(See Project Description Nº 29)

***Waste Management* – CSSS de la Montagne – Montreal, Canada**

In 2003, the Côte-des-Neiges site of CSSS de la Montagne conducted an audit of its waste materials. The purpose was to estimate the quantities of waste generated annually, estimate the current rate of recycling at the facility, and identify areas for improvement in order to achieve the recovery targets established in the 1998–2008 Quebec Residual Materials Management Policy (QRMMP). In 2006, thanks to the support of the members of its green team, the institution achieved a 64% waste recovery rate. This percentage, while below the 80% target set by the QRMMP, was nonetheless encouraging, particularly since few other health centres in Quebec have gathered this type of information.

(See Project Description Nº 30)

4 Water consumption

Healthcare institutions are big consumers of water for a number of reasons, including hygiene, prevention of hospital-acquired infections, use in food services and sterilization[5].

Did you know that...

While the average person uses 150–200 litres of water per day, in US hospitals the average patient needs 300–550 litres per day, and in Germany the average patient uses 300–611 litres of water per day[5].

Apart from the financial incentives driving many hospitals to reduce their water consumption, there is mounting pressure from employees who are concerned about sustainable water management. Changes implemented as part of a water conservation program also translate into improved quality of life for employees over the medium and long term (e.g. improved air quality when changes are made to ventilation systems, increased efficiency resulting from changes made to kitchen or laundry facilities).

TAKE ACTION

> Basic action

- Educate staff, patients and visitors about using water wisely;
- Identify and repair leaks as soon as possible.

> Reduction of domestic use

- Install low-flush toilets and urinals (verify the effectiveness of the flow reducers with other institutions where these are already in use);
- Install flow reducers and aerators on the faucets.

> Operating equipment

- Replace obsolete equipment with water-saving models;
- Recover condensation produced by refrigerators and freezers.

> Water supply

- Redirect condensation to boilers for reuse;
- Minimize water use for maintaining the grounds (install soil humidity controllers and automatic shut-off systems for when ground is moist);
- Reprogram washing machines to eliminate additional rinse cycles.

Projects

Water Conservation **– Milton Hospital – Massachusetts, United States**
This is a good illustration of how small changes can make a big difference. The replacement of one faucet in the Milton Hospital kitchen resulted in a considerable reduction in the water consumed for dishwashing, while at the same time eased the work of employees tasked with this responsibility.
(See Project Description Nº 31)

Water Conservation **– Carney Hospital – Massachusetts, United States**
Carney Hospital decided to reduce its water consumption by taking action in two areas: the refrigeration and air conditioning units, and the faucets in the examination and patient rooms.
(See Project Description Nº 32)

Water Conservation **– CSSS de Chicoutimi, Chicoutimi Hospital – Chicoutimi, Canada**
The CSSS de Chicoutimi needed to update the equipment in its laundry facilities and replace its operating room air conditioners with ventilation systems at the Chicoutimi Hospital. The employees affected were involved in the decisions regarding the changes to be implemented. This work not only translated into water and cost savings, but into an improvement in employees' working conditions over the short, medium and long term as well.
(See Project Description Nº 33)

Construction and renovation activities

"Buildings are a human habitat. The way we design, construct and operate these buildings has a profound impact on our health and the health of our environment. For too many years, the impact has been negative [...]. Often, indoor air is more polluted than the air outside and has been linked to illnesses ranging from asthma to cancer."

– Guenther, 2008

5

"Compared to other building types, healthcare facilities have an especially large impact on the environment."[19]. In the United States, healthcare construction is a US$41 billion industry[19]. The construction and operation of buildings requires billions of tonnes of raw materials, produces large volumes of waste and consumes a great deal of energy, to say nothing of the toxic pollutants released into the air[3].

Knowing this, it is safe to say that planning, designing and building ecologically responsible healthcare facilities would go a long way toward improving both human and environmental health.

TAKE ACTION

(adapted Green Guide for Health Care version 2.2, 2007)[20]

> Encourage the use of natural lighting in patient rooms and offices;
> Plan for spaces sufficient in number and size to accommodate the waste management system;
> Plan the location of new construction projects to be less than one kilometre from a subway or train station and less than 500 metres from one or more bus stops;
> Provide bicycle racks for at least 3% of employees;
> Plant vegetation on the grounds and prevent any work that could potentially damage the vegetation from being carried out within 40 feet of the building and within 10 feet of the driveway or access way;
> Provide patients and employees with outdoor and indoor rest areas that have a direct view of nature;
> Use paint and adhesives that do not contain volatile organic compounds;
> Eliminate mercury completely.

Green buildings use resources such as energy, water, raw materials, and soil in a more efficient way than structures that are only built to building code. Green buildings also generate less waste and emit fewer greenhouse gases. Knowing that we spend 90% of our time indoors and that the concentration of air pollutants inside can be five times that of the air outside, it is not surprising that people who live, work, and undergo treatment in green buildings are healthier, happier, and more productive[19].

It goes without saying, of course, that unless the daily management and operation of a green building is also respectful of the environment, the benefits of a sustainable building will be muted. It is critical, therefore, from the outset of any construction or renovation project, to plan for how the building will be operated:

> Plan for the future waste management system;
> Use environmentally friendly cleaning products;
> Train housekeeping staff, among others.

Without a targeted communications plan and the appropriate training sessions, we cannot expect employees to change their habits the moment they set foot in a new building, regardless of whether it is a green building or not.

Did you know that...

Compact fluorescent light bulbs contain small amounts of mercury, and, as such, they constitute a new way for mercury to find its way into our healthcare facilities.

Projects

***Green Construction* – Providence Newberg Medical Center – Oregon, United States**

From the moment it was decided to build the Providence Newberg Medical Center, the desire to obtain LEED certification was front and centre in the minds of those in charge of the project (see *Certification programs*, p. 175). Indeed, the hospital's senior management firmly believes in the relationship between environment and health. As such, building the hospital to the highest possible environmental standard was never in question.

(See Project Description Nº 34)

***Green Construction* – Alès Hospital – Alès, France**

Alès Hospital added a new building to its facilities in 2010. From the earliest stage of the project, the hospital's administration expressed a desire to build a green facility that would be in harmony with its environment and healthier for its employees and patients. Their efforts paid off, as Alès Hospital became the first healthcare institution in France to obtain High Quality Environmental Standard (HQE) certification.

(See Project Description Nº 35)

***Green Construction* – CSSS Lucille-Teasdale, CLSC de Rosemont – Montreal, Canada**

Seizing the opportunity of the construction of a building for the CLSC Rosemont, the CSSS Lucille-Teasdale and building owner Technopole Angus took all necessary measures to achieve Silver level LEED NC (new construction) certification (pending at the time of writing).

The ecological footprint of this new building, which opened its doors in the summer of 2010, is less than that of any comparable building; furthermore, it is healthier for employees and patients (e.g. improved air quality).

(See Project Description Nº 36)

6 Green procurement

"Green products have a reputation for being more expensive [...]. If we take into account aggregate costs, the reverse is true. While the initial investment is more substantial, so are the eventual savings."[a]

– Comité pour le développement durable en santé, 2010[(5)]

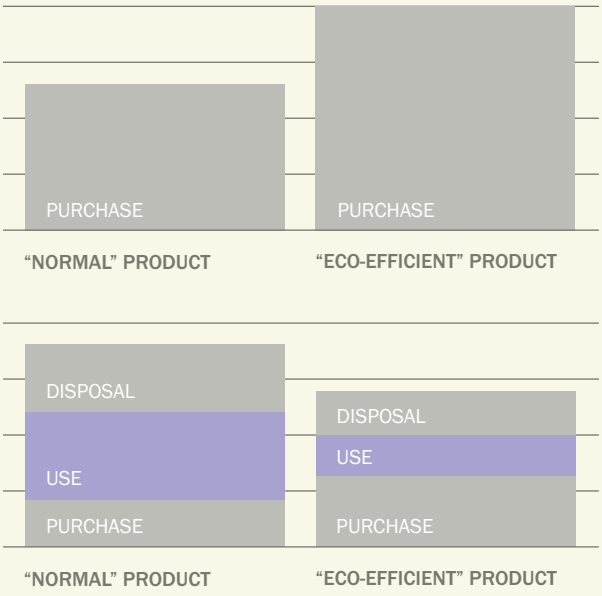
Healthcare institutions purchase thousands of products for their many departments. In Europe, healthcare facilities spend €15 billion in supplies every year[(5)]. Often, without realizing it, procurement officers purchase products that are toxic to employees, patients and/or the environment.

Green procurement means identifying products that are environment friendly. It also involves eliminating excess packaging and finding environmentally friendly substitutes for the products used. Our decisions as buyers can have a major impact on the quality of care we provide.

TAKE ACTION

1. Opt for products that:
   - Are less toxic;
   - Pollute as little as possible;
   - Are more energy efficient (e.g. Energy Star rated products);
   - Have a higher recycled content;
   - Have less packaging;
   - Are unscented;
2. Involve users in the choice of products;
3. Train your employees to use these products according to the manufacturer's specifications;
4. Notify all employees of any changes made.

Comparison of the hidden costs of two products throughout their lifecycle



Source: Deloach, L.C. (2010). *Greening Reaches the Operation Room*. Healthcare Design, Vol. 10, nº 7, p. 10–12. www.healthcaredesignmagazine.com

Projects

***Green Procurement: No More PVC!* – Lucile Packard Children's Hospital – Palo Alto, United States**

In 2001, the Lucile Packard Hospital for Children decided to eliminate polyvinyl chloride (PVC) from its intravenous systems. Why target PVC? Because it contains DEHP, a phthalate used to soften PVC (20–30% of its weight, and 80% in the case of tubing) that can leach out of PVC medical devices and have harmful effects on human health. A number of regulatory bodies around the world, including the US Environmental Protection Agency (EPA), are working to warn about the toxicity of DEHP and gradually phase out PVC and phthalates from the healthcare sector.

(See Project Description Nº 37)

***Green Procurement: No More Mercury!* – Philippine Department of Health – The Philippines**

The WHO and Health Care Without Harm are leading a joint international campaign to eliminate mercury-containing thermometers and sphygmomanometers in the coming decades and replace them with appropriate, inexpensive alternatives. The goal is to reduce the demand for mercury-containing thermometers and sphygmomanometers by 70% by the year 2017.

Before 2005, the dangers posed by mercury in healthcare facilities were not known in Southeast Asia. The first Southeast Asian conference on mercury was held in Manila in 2006. It was at this event that the Philippine Secretary of Health proposed to eliminate mercury from all hospitals in the country

(See Project Description Nº 38)

***Green Procurement: Pilot Project: Dairy Product Call for Proposals* – Regional group purchasing organization for the healthcare institutions of Saguenay-Lac-Saint-Jean (CRAG) – Chicoutimi, Canada**

In 2005, the organization's managers began reflecting on the network's social responsibility with respect to the sustainable development of the community. As part of a management exercise, the organization was mandated to conduct a pilot project applying the principles of sustainable development to a request for proposals for milk.

(See Project Description Nº 39)

7 Sustainable transportation

Healthcare institutions account for a considerable amount of transportation: the comings and goings of personnel and patients, the delivery of products that are necessary to facilities' operations, and the collection of waste materials.

Motorized travel has a significant impact on the environment and on health due to the associated production of greenhouse gases and many other air pollutants such as nitrogen oxides, volatile organic compounds, and particulate matter.

The contribution of transportation to air pollution in Quebec, Canada[22]

Nitrogen oxides	85% (year 2000)
Volatile organic compounds	39% (year 2000)
Particulate matter	17% (year 2000)
Greenhouse gases	37% (year 2003)

A study conducted in France, Switzerland and Austria (total population of 77 million people) using 2006 as a reference year estimated that air pollution due to transportation was responsible for[5] :

> 3% of total mortality in the three countries, or approximately 20,000 deaths;
> 25,000 new cases of chronic bronchitis in the adult population;
> More than 290,000 episodes of bronchitis in children;
> Over 500,000 asthma attacks;
> Over 16 million person-days of restricted activity.

The urban sprawl we are witnessing in many countries and the consequent use of motorized vehicles also have implications for the risk of obesity, traffic accidents and cardiopulmonary diseases[22].

TAKE ACTION

> Motivate your employees to carpool by:
- Setting up a "pairing up" website;
- Reserving the best parking spots for carpoolers;
- Offering them "guaranteed return trips for emergencies" in the form of taxi vouchers.

> Motivate your employees to come to work by bicyle or on foot by:
- Providing showers and lockers;
- Installing a sufficient number of bicycle racks (e.g. the norm in Quebec, Canada is one spot per 10_40 employees);
- Offering them "guaranteed return trips for emergencies" in the form of taxi vouchers;
- Offering them an annual "biking" or "walking" allowance in the form of bicycle repair tools or walking shoes.

> Motivate your employees to use the public transit system by:
- Allowing them to take out an annual subscription using automatic payroll deduction;
- Offering them free monthly passes (contests).

a This is an unofficial translation of the original quote.

Projects

***Sustainable Transportation: Shared Transportation of Patients* – Des Feuillades Functional Rehabilitation Centre, Sibourg Convalescent Centre and Parc Rambot Polyclinic – Aix-en-Provence, France**

In 2008, three healthcare facilities in the Aix-en-Provence region of France conducted a shared transport pilot project for patients receiving regular care at each of the three facilities.

This initiative is beneficial on two levels:

> Environmental: by driving three patients at a time instead of one, the drivers save two return trips and thus significantly reduce CO_2 emissions. The savings in fuel are also reflected in the health insurance budget;

> Social: as expressed by patient volunteers themselves, this measure encourages social contact and the creation of bonds with other patients, which in turn reduces anxiety associated with treatment.

(See Project Description Nº 40)

***Sustainable Transportation: "Access-Bike" Program* – CSSS de la Montagne – Montreal, Canada**

In 2006, this community health centre was seeking a way to improve the health of its employees, reduce its ecological footprint and set an example. It soon became clear that by addressing the issue of employee transportation, the centre could achieve all three objectives at once. The centre's catchment area lent itself particularly well to the use of bicycles for professional travel (e.g. home visits, inter-site travel).

(See Project Description Nº 41)

***Sustainable Transportation: "Go Green Transportation" Program* – Maisonneuve-Rosemont Hospital – Montreal, Canada**

In 2002, the Maisonneuve-Rosemont Hospital decided to implement the "Go Green Transportation" program. Precursor to the "Allégo" initiative, this program distinguished the hospital by directly targeting the quality of work life as well as attraction and retention of its employees. The potential benefits for staff were many: reduction in stress associated with traffic congestion, reduction in the risk of traffic accidents, time savings owing to designated lanes for buses and carpoolers, financial savings, improved physical fitness, improved concentration at work and, last but not least, a gesture to protect the environment.

(See Project Description Nº 42)

8 Energy efficiency

Simply by virtue of their operation, healthcare facilities—particularly those hospitals that operate around the clock—consume vast amounts of energy. In Brazil, hospitals account for approximately 11% of the country's total commercial energy consumption[23].

The health ministries of numerous governments have implemented ambitious energy conservation programs in order to simultaneously reduce costs, reduce dependence on fossil fuels, and reduce greenhouse gas emissions. Similarly, the Quebec ministry of health set the goal of reducing the energy consumption of Quebec's hospitals by 14% by March 31, 2009, relative to 2002 levels[24].

These large-scale initiatives often lead indirectly to better quality of work life for employees through improvements in such factors as air quality and temperature comfort, among others. A quick glance at the action plans of various green committees reveals the importance accorded to energy efficiency, even if these initiatives are on a more local scale than the major projects mentioned above. Examples of such initiatives include: awareness campaigns like "lights out when I leave my office," placement of stickers that read, "I turn off my computer at night," and many more.

TAKE ACTION

- **Turn out all the lights in your office when you leave in the evening;**
- **Configure your computer so that the screen goes into sleep mode after 10 minutes of inactivity;**
- **Turn off your computer when you leave at the end of the day (verify with computer services whether there are any problems associated with turning off your computer overnight);**
- **In summer, when the air conditioning is running, bring a sweater rather than turning on the heat;**
- **Report any abnormal functioning of the air conditioning or heating systems to technical services.**

Projects

Energy Efficiency **– Oregon Health and Science University's Center for Health and Healing – Portland, United States**

The Oregon Health and Science University's Center for Health and Healing was built according to LEED standards and was subsequently awarded the prestigious Platinum level LEED certification. The facility's administration used this construction project as an opportunity to implement advanced energy-efficiency design strategies.

(See Project Description Nº 43)

Energy Efficiency **– Sir Jamshedji Jeejeebhoy Hospital – Mumbai, India**

The Sir J.J. Hospital is one of the largest (1,352 beds) and oldest (150 years) hospitals in Southeast Asia. The agency responsible for the hospital's operation and maintenance implemented an awareness campaign to motivate staff to reduce their energy consumption.

(See Project Description Nº 44)

Energy Efficiency **– CSSS Richelieu-Yamaska, Honoré-Mercier Hospital – Saint-Hyacinthe, Canada**

As part of a large-scale renovation project at the Honoré-Mercier Hospital in Quebec, Canada, the facility had to proceed with a complete overhaul of its building envelope. The CSSS thus seized the opportunity to implement advanced energy-saving designs.

(See Project Description Nº 45)

Certification Programs

9

There are many certification programs dealing with environmental practices. The intent here is not to name them all but to present those that address the various strategies described in this chapter. In addition to attesting to the reduced environmental impact demonstrated by an institution, each type of certification below has the added advantage of requiring the institution to document all the steps it has taken, and to adopt a perspective of continuous improvement with respect to environmental performance.

LEED

The Leadership in Energy and Environmental Design (LEED) program is a highly respected North American building rating system. Today, LEED is the most widely used environmental rating system for buildings in the world and is the model on which most new systems are based. In addition to seeking to reduce the construction industry's use of resources, it also strives to raise community awareness about protecting the environment.

The LEED certification program takes a holistic approach to sustainability by recognizing performance in five key areas of human and environmental health:

> Sustainable site development;
> Water efficiency;
> Energy efficiency;
> Materials selection;
> Indoor environment quality.

A specialized LEED certification program for healthcare facilities has just been established in the United States. This new standard is the fruit of a close collaboration between the US Green Building Council and the Green Guide for Healthcare. It has been developed with the active participation of over 100 healthcare facilities across North America.

Source: www.usgbc.org – www.cagbc.org

Haute Qualité Environnementale (HQE)

Translated as "High-quality environmental standards," this French seal of approval was created in 1996 by the Association de la haute qualité environnementale, which brings together stakeholders in the construction industry for the purpose of developing a set of robust environmental standards that target 14 areas:

> *Green construction targets:*
  - C1. Harmonious relationships between the building and its immediate environment
  - C2. Integrated choice of construction methods and materials
  - C3. The avoidance of nuisance from the construction site

> *Green management targets:*
  - C4. Minimizing energy use
  - C5. Minimizing water use
  - C6. Minimizing waste in operations
  - C7. Minimizing building maintenance and repair

> *Indoor comfort targets:*
  - C8. Hydrothermal control measures
  - C9. Acoustic control measures
  - C10. Visual attractiveness
  - C11. Measures to control smells

> *Health targets:*
  - C12. Hygiene and cleanliness of indoor spaces
  - C13. Air quality controls
  - C14. Water quality controls

To adhere to the "HQE approach," a building must attain a minimum of:

> three targets at the very high performance level; or
> four targets at the high performance level; or
> seven targets at the basic performance level.

Source: www.assohqe.org (in French only)

9

ISO 26000

Published on November 1st, 2010, *ISO 26000* is an ISO standard that specifically pertains to the social responsibility of organizations in both the public and private sectors with respect to their application of sustainable development principles.

This standard defines social responsibility as an organization's obligations with respect to the impacts that its decisions and activities have on society and the environment. Social responsibility translates into transparent and ethical behaviour that:

> Contributes to sustainable development, including the health of individuals and the well-being of society;
> Engages stakeholders;
> Complies with laws and international standards;
> Is fully integrated into the organization and reflected in its relations.

Source: www.iso.org

FIND OUT MORE

Health Care Without Harm
An international coalition of hospitals and healthcare systems, medical professionals, community groups, unions and environmental organizations. Its mission is to transform the worldwide healthcare system to make it more ecologically sustainable without compromising the health or care of patients. This organization's website contains a wealth of information and resources.
Link: http://www.noharm.org/

Practice Greenhealth
A non-profit organization based in the United States that provides its members with tools, resources, forums, technical assistance and networking opportunities.
Link: http://www.practicegreenhealth.org

Comité pour le développement durable en santé (C2DS) [Committee for sustainable development in healthcare]
This French organization was created under the auspices of the French ministries of health and sustainable development. At its core, it is a collective of over 200 healthcare professionals, and on a broader level it brings together all of the stakeholders in the healthcare sector. The C2DS's four key missions are: to create ties with and influence public officials; to maintain an active network of members; to raise awareness among, train and guide healthcare institutions; and lastly, to focus attention on emerging issues.
Link: http://www.c2ds.com/

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Project Descriptions

4

Project

Description nº 1

Workplace Improvement Committee

Project	Workplace Improvement Committee
Institution	CSSS de Bordeaux-Cartierville-Saint-Laurent (Montreal, Canada)

Context

Aware of the significance of the healthcare and social services network reforms and their impact on the employees in this system, and further aware of the demographic data pointing to the accelerated aging of the population and short-term labour shortages, the CSSS de Bordeaux-Cartierville-Saint-Laurent was nonetheless determined to develop a comprehensive, superior service offering that would address the needs of its population. It undertook an organizational development initiative aimed at building an excellent reputation for itself, both internally and externally.

Objectives

Mobilize staff in order to:

- Attract and retain talent via actions adapted to the needs of today;
- Provide a stimulating and enriching work environment for everyone throughout the organization;
- Enable employees to focus their creative energy on client services;
- Make of the health and social services network reform something positive and constructive.

Implementation

The CSSS undertook a large-scale consultation exercise to identify the main actions it could take to earn the title of "employer-of-choice" within two to three years. Four themes were chosen:

1. Attraction and retention;
2. Working conditions;
3. Professional development;
4. Recognition.

The consultation panels were organized and facilitated by a coordinator from the HR working group. The panels were composed of one manager from HR, three other managers, three delegates from the professionals' committees and four union representatives, for a total of 12 members. The process got under way in 2008.

In addition, a think tank was established to address mangers' specific, self-identified needs. This group consisted of 11 managers.

The managers' consultation group gave rise to the following objectives:

1. Support managers in the performance of their role and promote work–life balance;
2. Support managers to improve effectiveness in the challenges involved in integrating services, quality and performance;
3. Create some leeway in order to support managers in the performance of their role.

Strategies employed

- Any employee interested in participating in this consultation process was able to do so, because incentives were put in place to encourage the sharing of ideas;
- The CSSS agreed to free up all personnel who wanted to take part in the consultation panels;
- Information meetings were also held with work teams and user/residents' committees.

Evaluation and results

The evaluation was conducted via discussion groups and interviews.

Employees greatly appreciated the extensive consultation and the participatory management of this project.

The indicators that will subsequently be used to measure the success of the project are:

- Absenteeism rate;
- Retention rate;
- Work climate study;
- Number of complaints of psychological harassment;
- Job openings.

Source: CSSS de Bordeaux-Cartierville-Saint-Laurent, 2009–2010 projects inventory.

Project

Description nº 2

Workplace Health and Wellness Program

Project	Workplace Health and Wellness Program
Institution	CRDI Gabrielle-Major (Montreal, Canada)

Context

Program developed in relation to the health and social services ministerial action on managing absenteeism (grant program).

Objectives

> Promote a healthy workplace using a comprehensive, integrative and preventive approach to health and wellness, whereby the goal is to instill in employees a healthy lifestyle with respect to both their physical and psychological health;
> Promote education, awareness, skills acquisition and improvement of employees' work environment in terms of workplace health and wellness. Inform staff about best practices and support their efforts to achieve health and wellness at work;
> Build employee motivation and job satisfaction by mobilizing them and creating a positive work climate that respects their values;
> Make strides in preventing and reducing absenteeism;
> Institute measures that will support employee attraction and retention;
> Achieve positive results on the healthy workplace indicators.

Implementation

Established a committee and defined its mandate, structure and operating rules.

Composition of the committee: employee representatives (different activity sectors within the organization) and persons with a genuine interest in improving the quality of work life.

Survey conducted to measure employee lifestyle choices (60% staff participation rate). The results of this survey served as a guide for the activities put in place.

Strategies employed

> Schedules and activity areas made accessible to all staff;
> Offer various activities relating to diet, physical activity and stress reduction;
> Financial support from employer.

Communication:

> Bi-monthly update in the organization's internal newsletter;
> Distribution of a calendar of activities twice a year;
> Information capsules, updates on the intranet site;
> Communication of information at employee annual meetings;
> Postings, memos, emails to the entire staff.

Evaluation and results

Quantitative evaluation by survey:

> Satisfaction survey for each activity (achieved 85-100% ratings for each activity);
> Survey on the impact of the program (78% reported that the program had an impact on their health and well-being. Of this 78%, 45% indicated an effect on their awareness level and 55% indicated a direct impact).

Qualitative evaluation: through discussions with work teams.

Success factors

> Taking into account the context of the organization and society in general in the annual planning of activities;
> Ensuring involvement of senior management by keeping the latter informed of developments in the program and the success of activities;
> Proposing a range of activities in order to appeal to the greatest number of individuals possible;
> Remaining attentive to the needs of employees, and validating and encouraging employee expression of needs.

Source: CRDI Gabrielle-Major, 2009–2010 projects inventory.

Project

Description nº 3

The Health Promotion Institute

Project	The Health Promotion Institute – portion presented: for staff only
Institution	University Mental Health Institute of Quebec (Quebec, Canada)

Context

Impetus for the initiative:

In 2006, new provisions of the *Tobacco Act* led to the formation of a working committee with a mandate to assess the feasibility of becoming a smoke-free establishment. The coercive approach was not working, so another approach was sought to address the issue.

Organizational context:

> Incidents receiving media attention were impacting the institute's reputation and employee morale;
> Tentative actions were taken pursuant to the work climate survey in 2005, but no institution-wide initiatives were introduced;
> Actions taken to reduce the disability leave rate were having little effect.

Objectives

> Offer employees tools and support to encourage them to take charge of their physical and psychological health;
> Develop activities to promote both physical and psychological health;
> Pursue the initiative to improve the work climate that began following the 2005 survey, which the 2008 survey further substantiated;
> Pursue efforts aimed, among other things, at reducing and preventing work-related injuries;
> Support smoking cessation.

Implementation

Established a pilot committee composed of: one coordinator, the director of finance, managers of various departments, one representative of the council of physicians, dentists and pharmacists, union presidents, one representative of the user committee, two medical experts from the regional public health authority, professionals, one public information officer in charge of communications, one administrative officer, other stakeholders relevant to the health topics in question.

One meeting per month, discussions encouraged among members of the pilot committee.

Established working groups for each health topic to be addressed. One team leader was named for each group, who was responsible for liaising between the working group and the pilot committee.

Strategies employed

> Offered the "Take Care of Your Health" program from ACTI-MENU;
> Created activities to promote and raise awareness about psychological health in response to the results of the work climate survey;
> Organized activities to motivate employees about fitness and linked these activities with external campaigns;
> Adopted a nutrition philosophy; encouraged healthy eating.

Evaluation and results

> Established the conditions that facilitate the introduction of changes;
> Observed evidence indicating the emergence and development of a culture of health;
> Fostered synergy among users, staff and health professionals in the implementation of the program;
> Employee testimonials regarding the benefits of the Take Care of Your Health program, specifically with respect to taking charge of their health and motivating them to take action;
> Pressure exerted to improve the menu offerings at the cafeteria resulted in better choices;
> Involvement of union partners was maintained during local negotiations;

Project

Description nº 3 (cont'd)

The Health Promotion Institute

- Employees offered suggestions for new activities to be launched;
- Positive effect on recruitment;
- Inspired external collaborators and partners to question their own practices;
- Trend observed toward a decrease in disability insurance expenses.

Success factors

- Opting for a global health promotion approach;
- Establishment of a pilot committee composed of key members (notably director of finance, physicians and union representatives);
- Care taken to position the concept within the organization: presentation to the various stakeholders, the organization's key groups and network partners;
- The initiative was deemed a priority for the organization; support from the board of directors and senior management;
- Allocation of financial resources;
- Participatory and motivating leadership;
- Transparency;
- Openness to changing the way things are done.

Source: Institut universitaire en santé mentale de Québec. (2010). *L'Institut promoteur de la santé,* [The health promotion institute]. Presentation given to the Montreal Health and Social Services Agency, September 22, 2010. www.institutsmq.qc.ca (in French only).

Project

Description nº 4

Kailo Worklace Wellness Program

Project	Kailo Workplace Wellness Program
Institution	Halton Healthcare Services (Oakville, Canada)

Context

In spring 2004, Halton Healthcare Services (HHS) surveyed its entire staff to assess their satisfaction with the organization as it related to their personal health.

Five objectives emerged from the results of this survey: 1. Employees work in departments/programs that are committed to improving quality of work life; 2. Employees know what is expected of them; 3. Managers know what is expected of them; 4. Employees feel that open communication is encouraged and information is communicated effectively; and 5. Employees feel supported and encouraged to make healthy lifestyle choices.

In June 2005, the HHS received a grant from Health Canada to implement an innovative workplace wellness program called the Kailo program, as a pilot project. This program, originally developed in the U.S., advocates a holistic approach that takes account of the full spectrum of needs identified by and for healthcare workers and incorporates a mind/body/spirit philosophy.

The Kailo program was employed to meet objectives 1, 4 and 5.

Objectives

> Build employee involvement in improving the quality of their work life;
> Encourage open communication and ensure effective communication of information;
> Support and encourage employees to make healthy lifestyle choices.

Implementation

Carried out by Kailo personnel in collaboration with HHS managers.

Strategies employed

The activities proposed by the Kailo program consisted of:

> Chair massage (most popular activity);
> Counselling (Kailo For One);
> Workshops:
  – Fostering team spirit, improving productivity and performance, reducing conflict, improving communication;
  – Health and wellness topics;
  – Creative pastimes.
> Wellness College: monthly presentations on various health and wellness topics;
> Special events provided three or four times per year;
> Newsletter;
> Monthly calendar of activities.

Evaluation and results

Quantitative evaluation by survey (60% response rate):

> 70% of respondents felt that this program set HHS apart from other employers, that it should be offered in other hospitals, and that participation in this program's activities fostered employee commitment;
> 58% felt this program helped them provide excellent care to patients;
> 60% found that the counselling service (Kailo For One) was useful to them.

Qualitative evaluation through discussion groups.

Success factors

> Support from senior management;
> Strong investment of Kailo personnel in HHS employees;
> Broad variety of activities offered, thereby responding to the needs of all employees;
> Continuous improvement of activities offered, notably in response to employee suggestions;
> Well thought-out communication and marketing plan.

Find out more

Taksas-Raponi, (2006) "Kailo: an award-winning approach to workplace wellness," *Hospital News*. Vol. 19, No 1, January 2006.

www.hospitalnews.com

Source: Halton Healthcare Services, 2009–2010 projects inventory.

Project

Description nº 5

An Integrative Continuous Improvement Project

Project	Healthy Workplace – An Integrative Continuous Improvement Project
Institution	University Geriatric Institute of Montreal (IUGM) (Montreal, Canada)

Context

The results of a 2005 survey spurred the IUGM to take additional measures to improve the workplace climate. The 2008–2011 strategic plan exercise uncovered an organizational issue of employee attraction and retention. As a Health Promoting Hospital, and being compliant with the Quebec standards bureau's Healthy Enterprise standard, the implementation with respect to a structured healthy workplace project seemed like the best means to achieve the institute's goals.

Objectives

> Establish favourable attraction and retention conditions for employees and physicians;
> Adapt management practices to conform to new values, such as work–life balance;
> Actively support employees in taking charge of their overall health;
> Achieve improvements in the various indicators of a healthy workplace.

Implementation

Be it in the identification of needs, strategic planning, development and implementation of policies, participation in various surveys, the implementation of a range of activities, participation in a number of committees, or participation in activities, all IUGM stakeholders were involved.

To begin with, the stakeholders were surveyed in order to profile the situation and needs. The institution then communicated its commitments (management policy and program). Various actions were then taken in the following areas: management practices, work–life balance, work environment, and lifestyle habits. Evaluations were conducted and improvements were made as needed. The results were validated by evidence from the evaluations, and the entire project became part of a continuous improvement initiative.

Strategies employed

Various strategies were put in place to encourage participation:

> Flexible schedules;
> Attractive prizes – exercise room, chair massages;
> Financial investment from employer;
> Project carried out on-site or in close proximity to work;
> Participation prizes;
> Recognition program.

Evaluation and results

This project was evaluated by means of group discussion, surveys, interviews and a validated questionnaire.

> Disability leave rate of 3.99 for 2008–2010 compared to the target rate of 5.2 for comparable institutions;
> Average employer contribution to Quebec's workmen's compensation commission was 1.21 in 2009. The IUGM had the best contribution rates of all healthcare institutions of comparable mission;
> Training investment rate of 2.55% of total payroll expenditures in 2007;
> 100% of survey respondents would use the employee assistance program again, if needed.

Success factors

> Firm commitment from senior management;
> Involvement translated into concrete actions;
> Implementation of activities that responded to the needs (identified a priori) rather than the imposition of a preconceived program;
> Team of collaborators who believe in the importance of the project;
> Dynamic leadership from the person in charge of the file;
> A continuous and permanent work-in-progress approach.

Source: University Geriatric Institute of Montreal, 2009–2010 projects inventory.

Project

Description nº 6

Mental Workload Management Model

Project	Mental Workload Management Model
Institution	Etelä-Savo Hospital District (Mikkeli, Finland)

Context

Practical experience and research data have shown that for staff to be highly motivated, their workload must be appropriate. The *Occupational Safety and Health Act* obliges employers to ensure employee safety at work. If it is suspected that an employee is subject to a seriously health-endangering workload, the employer must determine the factors causing the work overload. The same obligation applies whether the potential harm is physical or mental.

As there were many signs indicating that mental strain from workload had increased in the hospital's departments, a working group was created to develop a Mental Workload Management Model.

Description

Work management refers to the ability to influence work and the work environment. Specifically, this applies to the manipulation of either work operations or the working conditions under which the employee operates to perform his or her job.

The working group was responsible for developing the Management Model with the aim of finding different ways to identify and reduce mental harm due to workload.

This Management Model is dynamic, interactive, and practical, and is founded on effective methods of exercising leadership and shaping the workplace climate. The main goal of this project was to support the well-being of staff.

The management methods and indicators described in the Model are based on a review of the literature and the various systems used in the hospital district.

Evaluation and results

> Short-term absence, sick leaves and work-related injuries decreased somewhat compared to 2007;
> Work climate survey indicated that staff experienced an improvement in working conditions from 2007 to 2008.

Success factors

The Model has become standard practice and has been integrated into the Etelä-Savo Hospital district action plan.

Source: Etelä-Savo District Hospital, 2009–2010 projects inventory.

Project

Description nº 7

On the Other Side

Project	On the Other Side
Institution	Hospital of Santa Maria Nuova of Reggio Emilia (Reggio Emilia, Italy)

Context

The technicians and administrative staff of the mammography department were showing signs of needing support to improve relations with patients and reduce staff burnout caused by increased workload, which was itself due to an extension of the age range recommended for screening. The aim was to address the rapport between the women who access the breast screening service and the professionals who interact with them. Working on professionalism produces an improvement in service. Professionals thus needed support for the acquisition and development of skills, particularly in situations in which there are many pressures, both psychological and emotional.

Objectives

The main aims of the project were to improve relations between healthcare staff and patients, and minimize staff burnout.

Strategies employed

Interactive meetings with technicians and administrative staff, coordinated by a psychologist, every 15 days, focused on:

> Metaphorical relationship between disease and pain;
> Screening for disease, emotional burden on hospital staff ;
> Empathy as long-term exposure to the risk of burnout.

Evaluation and results

The project was evaluated by means of interviews and validated questionnaires concerning participants' satisfaction.

Source: Hospital of Santa Maria Nuova of Reggio Emilia, 2009–2010 projects inventory.

Project

Description nº 8

Establish Stable Care Teams and Regulate Operational Systems

Project	Establish Stable Care Teams and Regulate Operational Systems
Institution	Sacré-Cœur Hospital of Montreal (Montreal, Canada)

Context

This project was formed out of a partnership with CRISO (an organizational health research and intervention centre) and with the assistance of a CHSRF (Canadian Health Services Research Foundation) grant.

Through an action research framework, the aim of this project was to improve the working environment in order to increase staff attraction and retention, and regulate the operational systems to better support the care units.

The program targeted health, job satisfaction, well-being, the personal accountability entailed by such an initiative, and the concern for employee quality of life expressed through the organizational culture and management values.

Objectives

The project had two main objectives: improving the working environment and regulating the operational systems

Four sub-goals were further specified:

1. Develop the managerial skills of managers;
2. Address the psychosocial working environment of the care units;
3. Stabilize the work teams;
4. Increase the levels of job security and job satisfaction.

Implementation

This project involved more than 1,500 people and was adaptable to all hospital departments.

The formation of a CINCRO committee, made up of directors and assistant directors to control the dissemination of information and cohesiveness of the various activities. These individuals then carried out the project in their respective teams.

Evaluation and results

The project was evaluated by means of a focus group, survey, interview and validated questionnaire.

Project follow-up

The organizers of the project are aiming to integrate it into the hospital's standard practices. It has, in fact, formed the basis of the hospital's new strategic plan.

Success factors

> Involvement and availability of managers.

Source: Sacré-Cœur Hospital of Montreal, 2009–2010 projects inventory.

Project

Description nº 9

Health Professions Today: Clarifying Professionals' Roles

Project	Health Professions Today: Clarifying Professionals' Roles
Institution	Local Health Unit of Bologna (Bologna, Italy)

Context

Intervention regarding professional group competencies (social service and healthcare providers, nurses, doctors, midwives) was justified and inspired by the results of a psychological and social risk evaluation wherein role ambiguity appeared to be the specific risk factor in the professions studied. An analysis of the data revealed that the professionals lacked sufficiently clear information about their job description and responsibilities, their colleagues' expectations and their tasks. This was causing low job satisfaction, high levels of a sense of ineffectiveness, and significant decreases in self-esteem.

Description

It is important to reorient the perceptions of professionals in order to reinforce professional identity. For this reason, this project analyzed the factors that define the professional roles of health staff through the balance of competencies.

Strategies employed

This project was divided into two phases:

1. During the first phase, discussion groups on professional roles were organized around issues more specifically related to identity. The data collected were analyzed using a cluster analysis with TLAB software.
2. In the second phase, through narrative methodology, professionals became aware of their real personal competencies and the ones required by the organization.

Evaluation and results

The units in which the intervention was conducted registered fewer leaves and a high level of attendance at the monthly professional meeting.

> Rate of absenteeism: reduction of 50%;
> Presence at meetings: increase of 30%.

Success factors

The success of the project is due not only to the individual changes made but, more importantly, to having management procedures on which to fall back. The professionals became more aware of their skills and duties, and this allowed them to establish positive relationships with other colleagues because they no longer had to struggle to assert their own job parameters.

Source: Local Unit Health of Bologna, 2009–2010 projects inventory.

Project

Description nº 10

Weeks for Joy of Living

Project	Weeks for Joy of Living
Institution	Central Finland Health Care District (Finland)

Context

As a member of the HPH network since year 1988, our health care district wanted to concentrate more on health promotion and empowerment among employees. This is one of the main issues in the District Health Promotion action programme for the years 2009–2013. Psychological well-being is the main focus of the program, added to healthy lifestyle. The healthy workplace committee pointed out the need for new tools for employee health promotion. Health promotion contact persons from different units of the healthcare district first created the idea of a Week for Joy of Living.

Description

The idea was to offer hospital employees the opportunity to use their skills, abilities and knowledge for the joy of others. Different units of the hospital were invited to create an activity that fosters collective well-being. In addition, some special events were planned to motivate individuals, and different units were challenged to join in the action, involving a total of 4,200 employees. Planning was designed to be very easy and the activities organized without using extra money. The health promotion and prevention unit took care of coordination, and the district management board confirmed the continuation of the program in future.

Evaluation and results

- Group activities, e.g. empowering photos, “power of colours” workshop, dance lessons, InBody body composition analysis and personal feedback;
- The Joy of Living Market, with presentations on culture, sports, travelling, etc;
- Offers of free or inexpensive access to theatre performances , concerts and art exhibitions;
- Playful competitions, e.g. “The Art Toilet” or “Joy of Workplace” photographs;
- The members of the hospital management board meeting the employees in an open café.

Success factors

The model was first implemented for one week in November 2009. The employees suggested repeating it for one more week at a later date.

The model has been established as a good practice for health promotion and empowerment among employees and has been integrated into the annual strategy.

Source: Central Finland Health Care District, 2009–2010 projects inventory.

Project

Description nº 11

Improving Employee Attraction and Retention Practices

Project	Improving Employee Attraction, Involvement and Retention Practices at the CRME
Institution	Sainte-Justine University Hospital Centre –Rehabilitation Centre Marie Enfant (CRME) (Montreal, Canada)

Context

Given the labour shortages in the health system, the CRME's labour committee mobilized itself to implement employee attraction, engagement and retention initiatives at the CRME. Difficulty in recruiting staff was the impetus for the project. In addition, numerous mandatory changes to the organization of work were impacting the motivation of professional, management and support staff alike.

Objectives

> To become an "employer-of-choice";
> To identify the aspects of employees' work environments they consider important and appealing;
> To improve employee attraction, engagement" and retention practices.

Implementation

Staged approach, and thus creation of working committees by stages: attraction, engagement and retention.

> Information gathering (focus group, pre-project interviews, etc.);
> Data analysis and making recommendations.

Evaluation and results

The project was met with great enthusiasm by participants, resulting in a high level of involvement in the establishment of committees and planning of activities.

Success factors

> Staff participation in meetings;
> Institutional support for the initiative;
> Opportunity to carry out the recommended solutions.

Source: Sainte-Justine UHC, CRME, 2009–2010 projects inventory.

Project

Description nº 12

Support Group

Project	Support Group
Institution	CSSS du Sud-Ouest Verdun – Yvon Brunet Residence (Montreal, Canada)

Context

This residence was showing a relatively high rate of absenteeism caused, among other things, by personal problems experienced by employees. This situation seemed to call for support in this area. This initiative has been in place for eight years now, and four training sessions have taken place in that time.

This project constitutes a preventive psychological health initiative, whereby certain employees, chosen by their peers subsequent to receiving training in providing support and listening, offer informal and confidential support in the work setting. Participation in the program is voluntary, and a one-day retreat on various themes is offered once a year.

Objectives

Offer an informal, internal resource (very different from traditional Employee Assistance Programs) to assist employees in dealing with personal problems. The program also aims to reduce disability leave costs over the long term

Implementation

In the support groups and during the training programs, the project brings together people from various employment categories, including clinical, clerical, technical and management staff.

The project was presented to the union, senior management and all employees in order to seek and obtain their endorsement.

Strategies employed

The residence offered a two-day paid training program to employees selected by their peers and ensured their replacement when they needed to invest time in projects intended to benefit the whole staff.

Regular group activities of several kinds: recognition by sending notices to all employees, car washes, etc.

Good cooperation from unit managers in accommodating necessary schedule adjustments.

Evaluation and results

The results of this type of project are difficult to quantify. However, the assistance, attention, support, and activities within the work setting definitely had a positive impact.

Success factors

- Involvement of senior management;
- Having one person in charge of the project present as regularly as possible;
- Holding activities that bring together the whole group;
- Maintaining regular communication;
- Ensuring that all actions are initiated and carried out by the members themselves.

Source: CSSS du Sud-Ouest Verdun – Yvon Brunet Residence, 2009–2010 projects inventory.

Project

Description nº 13

Fostering a Respectful Workplace and Preventing Violence

Project	Fostering a Respectful Workplace and Preventing Violence
Institution	Chatham-Kent Health Alliance (Ontario, Canada)

Context

The Chatham-Kent Health Alliance (CKHA) participated in the Ontario Hospital Association/Workplace Safety and Insurance Board Safety Group. Safety Groups are designed to recognize organizations that make prevention a daily habit by building prevention elements into their management systems. CKHA is committed to preventing workplace accidents and illnesses. In 2006, one of the elements that Chatham-Kent determined to be important was the development of a Workplace Violence Prevention Program. A team comprising expertise from clinical and non-clinical areas, and with the support of senior administration, began to collectively assess the need for such a program. This program has grown in the last three years, with many different workplace violence prevention programs being added to enhance and support a safe and healthy work environment.

At a staff focus group entitled "If You Only Asked Me," bullying was identified by staff as a number one concern at CKHA.

Objectives

> To prevent any incidence of bullying, violence, harassment or discrimination;
> To provide all staff, management and physicians with the education and tools to identify, report and/or manage any potential or actual incidence(s) of violence in the workplace.

Description

A Workplace Violence Prevention Steering Committee was assembled to address management and prevention of violence in the workplace. The work of the committee has included the following:

> The Code of Conduct Policy was revised based on a literature review, legal counsel feedback and staff input. The Policy was reviewed and approved by the Executive, Medical Advisory Committee, Mission & Quality Committee and Tri-Board;
> The Policy was communicated to staff through Code of Conduct education sessions. Other related policies that have since been created and/or revised include: Anti-Harassment and Discrimination Policy; Code of Conduct: Patients, Families and Visitors; Violence: Management in the Workplace; Domestic Violence Policy; Safe Room Policy;
> Three-day Bullying Incident Investigation workshops were provided for managers;
> One-day Anti-Bullying workshops were provided for staff and physicians;
> Half-day workshops on Conflict Management through Respectful Interaction were provided for staff and management;
> "VOCERA", a wireless communication tool, was implemented to increase staff safety in high-risk units – inpatient Psychiatry Unit, Women and Children's Health Program, and the inpatient Surgical Unit;

Project

Description nº 13 (cont'd)

Fostering a Respectful Workplace and Preventing Violence

- A workshop on "Recognizing and Handling Disruptive Physician Behaviour at CKHA" was offered to physicians and was facilitated by the Chief of Staff and VP/CHRO; the workshop was based on the recently released *Guidebook for Managing Disruptive Physician Behaviour* published by the Ontario College of Physicians and Surgeons;
- A Domestic Violence Awareness Policy and a campaign were implemented to provide guidance to management and staff in addressing these issues in the workplace;
- A Safe Room Policy was created and specific rooms have been designated/equipped as Safe Rooms for staff.

Evaluation and results

Occupational health and safety has experienced an increase in reporting of incidents – which was anticipated and shows the success of the program. Staff members are now comfortable with reporting incidents, knowing that there will be follow-through. They next anticipate a decline in bullying and disrespectful behaviour as staff, management and physicians realize that violations of our code of conduct are unacceptable and will not be tolerated.

Success factors

- Chatham-Kent Health Alliance is committed to having a safe and healthy workplace, free from violence. It is this unwavering commitment to staying the course that explains the success of these programs;
- Healthcare workers are more aware of their rights and responsibilities surrounding workplace violence prevention programs. These programs have instilled confidence in employees to report any workplace violence issues, knowing they will be addressed in a fair and consistent manner;
- The magnitude of the training of management and healthcare workers, and the development of various workplace violence prevention programs, demonstrates the commitment Chatham-Kent Health Alliance has made;
- The proactive implementation of multiple workplace violence prevention programs demonstrates to staff that the administration is forward-thinking.

Source: Chatham-Kent Health Alliance, 2009–2010 projects inventory.

Project

Description nº 14

The Clinico-Legal Intervention Committee

Project	The Clinico-Legal Intervention Committee
Institution	The West Montreal Readaptation Centre, the Lisette-Dupras Rehabilitation Centre and the Gabrielle-Major Rehabilitation Centre for Intellectual Disabilities (Montreal, Canada)

Context

In 2005 the West Montreal Readaptation Centre initiated a pilot project aimed at creating an intervention committee that was equipped with both clinical and legal expertise. Through this committee, this centre for people with intellectual disabilities and pervasive development disorders wished to reflect on challenging clinical cases that have potential legal implications. These issues concerned the entire institution. Following the success of this pilot project, the Clinico-Legal Intervention Committee (CLIC) was instituted in two other similar centres, the Lisette-Dupras centre (2006) and the Gabrielle-Major centre (2007).

Objectives

> Guide and support clinical teams and managers with respect to difficult users who present an elevated risk to themselves, to others and/or to the institution, or who otherwise pose a significant risk;
> Offer clinical teams organizational support in managing difficult cases;
> Play a role of forum and mediator.

Implementation

The CLIC intervention complements the centres' risk management and clinical practice improvement systems.

The CLIC works with clinical teams and managers in a complementary way and intervenes only upon request or when the Professional Services and Quality Directorate determines that there is a high risk of injury or harm to the CLIC user, to others or to the institution.

Strategies employed

The clinical teams, managers and decision makers may call on the CLIC for an assessment, consultation or intervention concerning a user of one of the centres.

The CLIC may call on external expertise when necessary, such as the office of the public guardian and trustee, private guardian/trustee, family council, youth centre, researcher, etc.

Evaluation and results

> 50% reduction in the number of similar cases referred to the CLIC;
> 80% reduction in the return of the same cases before the CLIC;
> 80% satisfaction rate among employees who used the CLIC;
> 50% reduction in acts of aggression against CLIC users in the year following the CLIC consultation;
> 50% reduction in the number of calls placed to the police in the year following the CLIC consultation.

Success factors

> The CLIC is a model for integrating clinical, organizational and legal interventions in a rehabilitation setting (i.e. people with intellectual disabilities or pervasive developmental disorders);
> It answers a need for reconciliation of these issues from a clinical practice perspective;
> It constitutes an attempt to reconcile the users' human rights, their clinical needs, personal expectations, and other aspects of the clinical setting as well as the values in play.

Source: The West Montreal Readaptation Centre, the Lisette-Dupras Rehabilitation Centre and the Gabrielle-Major Rehabilitation Centre, 2009–2010 projects inventory.

Project

Description nº 15

Adaptation of the Magnet Hospital Model

Project	On the Road to Excellence: Adaptation of the Magnet Hospital Model
Institution	Montreal Shriners Hospital for Children (Montreal, Canada)

Context

To develop and maintain a healthy environment, the hospital established various programs to meet the objectives of its fundamental values.

The hospital established an environment that supported the following initiatives: communication, recognition, professional development, participatory management, and employee health and well-being programs.

The care quality and safety improvement program and the multidisciplinary research clinic program contributed to the establishment of a healthy workplace.

Objectives

> Reduction in absenteeism;
> Employee attraction;
> Employee retention;
> Quality of work life;
> Work–life balance.

Implementation

A proactive approach to meeting objectives was used to create an optimal working environment.

All employees and managers were involved daily in these practices, and supported them.

Strategies employed

The project led the Shriners Hospital for Children to develop and implement several clinical, educational and management programs and practices that are conducive to a healthy workplace environment, consistent with the attributes of a Magnet hospital.

Evaluation and results

This project was evaluated by means of group discussion, survey, interview and validated questionnaire.

> Absenteeism rate less than 5%;
> Employee turnover of 1%;
> 85% satisfaction rate based on a satisfaction survey.

Success factors

> Involvement and participation of all actors (commitment);
> Involvement and support of the board of directors;
> Ongoing evaluation.

Source: Shriners Hospital for Children, 2009–2010 projects inventory.

Project

Description nº 16

An Individual Approach to Risk Factors for Employees

Project	An Individual Approach to Risk Factors for Employees
Institution	East Tallinn Central Hospital (Tallinn, Estonia)

Context

The idea for this project arose directly from practice. An employee who is unaware of the risk factors in the work environment or who ignores safety requirements puts his/her health and that of his/her colleagues or patients at risk.

Objectives

> To devise a system for assessing risk and to implement prevention measures throughout the hospital, in order to provide an individual approach for employees, to keep them informed and cooperative;
> To introduce the list of individual risk factors for the employee.

Implementation

The working group consisted of the manager of the Work Environment Service, the head of the Education and Training Department, and an occupational health physician (member of the Estonian Association of Occupational Health Physicians).

Strategies employed

> An employee starts work, receives the necessary instructions, individual guidance, training and a health check. All required documents are filed, including the list of risk factors;
> At the time the health check is performed, the Work Environment Service provides the occupational health physician with a list of risk factors for the employee and a risk analysis for the department or subunit;
> The occupational health physician informs the employee of the results of the health check;
> The physician's recommendations provide information on problems that need greater attention;
> The results of health checks provide important information about the effects of the risk factors on the health of the employee;
> The recommendations and suggestions for changing work procedures or working conditions are used to re-evaluate the risks for an employee and are presented on the list of risk factors;
> The employee's immediate supervisor is responsible for the implementation and follow-up of the recommendations;
> The need to adapt workplaces has diminished considerably as the working conditions are updated.

Evaluation and results

The number of reported accidents increased after the program was implemented in 2005:

Year	2005	2006	2007
Total reported cases	24	33	36

This shows the increased awareness of the 1,600 employees. They did not try to cover up the accidents, but reported them according to the established procedure.

Through interviews and a survey, the working group identified the following elements:

> A well-informed employee knows how to protect his or her health and to prevent health problems;
> Cases are brought under control, statistics are gathered and the results are analyzed;
> Information is used to update action plans for preventing and reducing risks at the hospital;

Project

Description nº 16 (cont'd)

An Individual Approach to Risk Factors for Employees

> Information is used to notify employees, to give them guidance, instruction and training;
> The individual approach makes the employee feel secure;
> Dedicated employees improve the competitiveness of the hospital.

Success factors

Identifying and assessing individual risks provides consistent information and an opportunity to make dynamic changes and additions to employee training programs, and to take into account the need to improve working conditions and the work environment.

Opportunities provided to an employee:

> The employee is aware of the risks – this is ensured by the guidance procedure;
> The employee knows how to prevent risks – obligation to succeed in the instruction class and obtain the required training;
> The employee knows what to do if the risk materializes – a procedure has been established.

Source: East Tallinn Central Hospital, 2009–2010 projects inventory.

Project

Description nº 17

Preventing Musculoskeletal Disorders

Project	Preventing Musculoskeletal Disorders (MSDs) in Nursing Staff and Caregivers
Institution	East Tallinn Central Hospital (Tallinn, Estonia)

Context

The idea behind this project arose directly from practice. One of the principal tasks of nurses and caregivers in the hospital is to help patients while they carry out their daily activities. The nursing staff and caregivers must reposition patients, support them and help them remain in the position required. About two-thirds of all hospital staff are required to carry out this type of work. All the risk factors for hospitals affect the health of nurses and caregivers, causing lumbago and health problems for the neck, arms and back. These problems can lead to an inability to work in the long term.

The institution decided to map the main problems encountered in the workplace and to create a monitoring and training system.

Objectives

> Ensure that the staff responsible for physically repositioning or moving patients (or for assisting in such manoeuvres) do so using the appropriate techniques.
> Provide a safe workplace with respect to preventing muskuloskeletal disorders.

Description

The East Tallinn Central Hospital uses an integrative approach to the prevention of musculoskeletal disorders. This approach focuses mainly on the effectiveness of knowledge transfer among the departments and services, and also on doing more to sensitize employees to health and safety issues. In collaboration with the structural units, the Work Environment Service, the Workplace Health Department, and the department responsible for training combined forces to reach this objective.

> Risks are assessed, including the principal risks for, and problems of, employees who have to move patients manually (repositioning or transfer);
> Those in charge of the structural units assess the needs of all the employees in light of the results of the risk assessment, the recommendations from the staff doctor, the existing working conditions and the application of knowledge acquired during previous training;
> Based on the information received, the training centre develops training programs for manual movement of loads and notes the names of the participants. Training is offered at different stages by a physiotherapist.

Evaluation and results

Evaluating training requirements resulted in the development of training programs that matched the actual needs of a department or of a specific group of employees. The training centres transferred the organization of the workshops to the departments. Employees are aware of their rights, their responsibilities and their opportunities for self-improvement. They know to whom to turn for any problem they encounter, and actively participate in seeking solutions.

All this helps to create an environment in which good working conditions and employee awareness reduce the number of workplace accidents and musculoskeletal disorders.

Success factors

> Good cooperation among the structural subdivisions;
> Accessibility of information;
> Continuity of activities.

Source: East Tallinn Central Hospital, 2009–2010 projects inventory.

Project

Description nº 18

The Management of Dangerous Drugs

Project	The Management of Dangerous Drugs at the Sherbrooke UHC – Why and How
Institution	Sherbrooke University Health Centre (Sherbrooke, Canada)

Context

A discrepancy existed between the scientific data (NIOSH Alert 2005: exposure is a risk at any point along which hazardous medications circulate through the hospital), the number of protective measures in place, and the employees' awareness of this risk (only staff working in the chemotherapy centre and the oncology pharmacy expressed any concerns).

Objectives

> To ensure the health and safety of health professionals, physicians and non-clinical staff;
> To increase the measures for, and the levels of, protection during the handling, preparation and administration of hazardous drugs;
> To prevent contamination of the environment and of individuals in the complex process affecting a multitude of people and services;
> To modify work procedures and to make sure that behaviours are modified in a sustainable way.

Description

The head of Occupational Health and Safety was responsible for the project; he set up an implementation committee and hired a project leader.

The committee carried out an assessment of the situation, developed policies and procedures, and designed a training program and a plan for implementing new safety standards.

The committee decided on the necessary safety procedures, taking into account the realities of the workplace and the potential for adherence to the standards.

Activities: publication of a handbook on policies and procedures for the safe handling of hazardous drugs, training of all personnel at risk, on-the-ground interventions on demand (meetings on site), support for work teams, development of tools to facilitate the application of the standards, evaluation of needs in individual protection equipment, environmental monitoring.

Employees working in at-risk areas were targeted at the beginning of the project; subsequently, the measures were gradually extended to employees in all areas.

Evaluation and results

Establishment of a standing monitoring committee responsible for:

> Certification procedures;
> Continuing education programs;
> Environmental monitoring program;
> Updating policies and procedures, as well as the list of hazardous drugs;
> Preventive maintenance and cleaning of the facility.

Success factors

> Hiring a person responsible for the project with expertise in the handling of hazardous drugs;
> Setting up an interdisciplinary committee of experts;
> Support from management;
> Follow-up in the units;
> Providing concrete tools to help unit personnel.

Source: 2010 ASSTSAS Conference: *La prévention, comme la magie, ça s'apprend! [Just like magic, prevention can be learned!]*

Project

Description nº 19

A Well-Organized Program for an Adapted Return to Work (PRATA)

Project	A Well-Organized Program for an Adapted Return to Work (PRATA)
Institution	Bas-Saint-Laurent Health and Social Services Agency, CRDI du Bas-Saint-Laurent, CSSS de Témiscouata, CSSS de Kamouraska (Bas-Saint-Laurent, Canada)

Context

An exploratory study of MSD cases reported between 2006 and 2008 revealed the human and economic impact of MSDs within healthcare institutions in the Bas-Saint-Laurent region of Quebec, Canada. Findings indicated difficulties in handling the more complex cases and in reintegrating these employees into the workforce. This study also revealed an opportunity to improve costs in terms of disability insurance and worker's compensation.

A new, self-financed initiative has been launched that provides a rehabilitation professional who is strictly dedicated to working with employees returning to work-with functional limitations. This program (PRATA) has just been added to existing workplace health promotion services and is offered to healthcare institutions in the region by the team from the Agency's Regional prevention and health promotion services for workers.

Objectives

- To support and encourage affected workers to remain in the workplace, while taking into account their injury;
- To improve the conditions for the return to work and for supporting workers with MSDs;
- To improve the prevention measures for workers at risk of injury;
- To develop and share professional skills and pertinent information among participants from OHS services and its partners (union, attending physician, private clinics, etc.).

Anticipated benefits

- Minimizing relapses, recurrences or worsening of injuries;
- Making new human resources available;
- Reducing the duration and average cost of MSD injuries;
- Self-financed program and reinvestment in prevention.

Description

For each returning employee whose file is retained, a PRATA committee composed of the employee, the employee's supervisor or manager, a union representative, a representative from the OHS department, and the rehabilitation/prevention advisor is set up. The committee operates in an interdisciplinary fashion within a set framework to resolve problems related to the reintegration of the employee and develops a return-to-work plan adapted to the employee's specific needs.

The approach includes taking minutes of meetings and reporting the preventive steps taken. All documentation produced is validated, then distributed to all the participants involved, including the attending physician and medical personnel, in order to optimize everyone's efforts. A copy is also sent to the official agencies involved and to the insurance companies.

Mass distribution of the program: development of a local and regional communication plan.

Project

Description nº 19 (cont'd)

A Well-Organized Program for an Adapted Return to Work (PRATA)

Evaluation and results

After 24 months:

> Estimated savings of $400,000 in 2008–2009;
> Reduction of over $500,000 in costs of overall absences within and across the nine institutions participating in the 2009–2010 program;
> 37% reduction in the duration of absences from work between 2006 and 2009;
> 24% reduction in the average cost of absences between 2006 and 2009;
> 72 workers supported by PRATA since October 2008, and 90 workers since 2006;
> 90% of PRATA cases last less than four months, thanks mainly to the monthly meetings;
> A new dynamic has been created within in the institutions.

According to the results of the satisfaction survey of program participants (over 60% response rate), the program has been deemed a success by everyone involved (workers, managers, union and OHS representatives.

Success factors

> Introduction of a climate of trust;
> Consensual decision making;
> Sharing of information throughout the process;
> Division of tasks and respect for roles and responsibilities.

Source: 2010 ASSTSAS Conference: *La prévention, comme la magie, ça s'apprend! [Just like magic, prevention can be learned!]*

Project

Description nº 20

Bonus Day to Promote Staff Well-Being

Project	Bonus Day to Promote Staff Well-Being
Institution	Raahe Health and Wellness Area (Raahe, Finland)

Context

It is well known and has been demonstrated that the staff of healthcare institutions have a tremendous influence on patients, relatives, visitors and other contact persons with respect to promoting health and well-being. We felt it was important, as a first step, to find out how great a proportion of our staff was pursuing a healthy lifestyle, and whether this had at least some impact on job satisfaction and overall positive feelings associated with work. Secondly, a bonus day seemed like an appropriate incentive for the staff to strive for a healthier lifestyle.

Objectives

> To discover what percentage of staff were eligible for the bonus day and on what grounds (i.e. which of the four criteria did they meet);
> To learn the status of healthy lifestyle and well-being of the hospital via a survey completed by all staff.

Implementation

Four determinants of staff health and well-being were selected as the main criteria for participant success in this project: smoking cessation, weight maintenance (either a BMI of 28 or less, or a weight reduction of at least 5 kg), overall good or excellent physical fitness (measured by a walking exercise test or another broader exercise test), and no sick days taken during the project year. One bonus day, consisting of one day off, paid at full salary, was granted to all employees who met two out of the four criteria. Additionally, all staff members were required to complete an anonymous survey on their lifestyle.

Evaluation and results

> The number of bonus-day eligible staff out of the total full-time staff: 369/700;
> The percentage of bonus-day eligible staff vs. the total staff who smoke: 3% vs. 18.1%, respectively;
> The percentage of bonus-day eligible staff vs. total staff who consume alcohol: 61.5% vs. 73%;
> The percentage of bonus day eligible staff vs. total staff, who consume less than 6 servings of alcohol per week: 95.1% vs. 82.5%.

Success factors

Working in health services is demanding, both mentally and physically. Public health services have a limited number of incentives in use to promote healthier lifestyles for staff. The awarded bonus days were used quite extensively, and the staff appreciated them. We believe it has also encouraged those who were not eligible for the bonus day the previous year to consider the options for becoming eligible.

Source: Raahe Health and Wellness Area, 2009–2010 projects inventory.

Project

Description nº 21

Activators

Project	Activators
Institution	Oulu University Hospital (Oulu, Finland)

Context

Motivating staff to change their lifestyles for the better and improve their well-being.

Objectives

1. Through counselling in exercise and dietary habits, succeed in making long-term changes in lifestyle and reducing the type 2 diabetes risk profile within the group targeted by this program.
2. Significantly increase physical fitness using a personal exercise plan.
3. Succeed in changing dietary habits as a result of receiving personalized nutritional counselling.

Description

The target group in this project consisted of 30 female employees of the Oulu University Hospital who were at high risk for developing type 2 diabetes. They were selected for this program based on their scores on a risk test for type 2 diabetes. All of them had a score of over 15, and all were overweight.

The project was carried out as part of a larger D2D project of the Northern Ostrobothnia Health Care District, entitled Fit Through the Ages.

The aim of the Activator project was to determine whether an exercise and nutrition lifestyle-change group would be successful in promoting long-lasting lifestyle changes and diminishing risks for type 2 diabetes. In addition, personalized exercise plans to promote better physical fitness were provided, along with nutritional counselling for healthier dietary habits to encourage the group.

Health examinations were performed by an occupational therapist at the beginning and end of the project.

The medical examination included measuring weight, height, BMI, waist circumference, blood pressure, glucose tolerance, and blood lipids. Each participant was provided with a personalized exercise and nutrition plan. Twenty group activities were arranged, three of which were discussions led by a psychologist, and the balance were meetings dealing with nutrition and exercise topics.

Exercise activities included gym workouts, walking in the pool or with ski poles, snowshoeing, ball games in the gymnasium, rowing and bowling. Nutritional themes in the group sessions included eating speed, healthy snacks, the amount and type of fat intake, dietary fibre, salt and sugar, interpreting package information and eating discipline.

Topics discussed at meetings led by the psychologist included weight control goals, motivation, relapsing, and maintaining lifestyle changes.

Evaluation and results

The participants responded to the personal exercise and nutritional plans enthusiastically and were highly motivated. Similarly, the group meetings helped promote team spirit and motivated people to strive for new goals in diet change and exercise.

Keeping up with an individual exercise and nutritional plans had a great impact on improved physical fitness and diet change. The more closely participants followed their individual plans, the more committed they were to the group.

The project became a formal program, which is now offered to work units to promote employee health. Follow-up is carried out at the beginning and end of each project, as well as at the end of two years, if desired.

Success factors

> Personal exercise and dietary plans were inspiring and motivating;
> Group meetings:
  - Supported positive group spirit;
  - Helped motivate participants to set new dietary goals for themselves;
  - Made it easier to try new exercise alternatives in order to find the ones most suitable.

Source: Oulu University Hospital, 2009–2010 projects inventory.

Project

Description nº 22

Health Comes from Eating Healthy

Project	Health Comes from Eating Healthy
Institution	Hospital of Santa Maria Nuova (Reggio Emilia, Italy)

Context

When it comes to health in the workplace, obesity and its associated diseases negatively impact on people's capacity for manual load handling, carrying out shift work, and adapting to ergonomic work areas.

Hospital healthcare staff are more informed about obesity and its effects on the population, but this does not always mean that they are models of health or of healthy lifestyle behaviours.

Objectives

As a prevention initiative, the aim of the project was to identify and reduce risk factors associated with excess weight and nutrition-related disease among the entire staff of the Reggio Emilia Hospital.

Goals of the internal survey:

- To identify the prevalence of excess weight (overweight and obesity), related cardiovascular diseases, and health risk factors among the hospital staff;
- To create and deliver an educational program on the acquisition of healthy lifestyles, particularly with respect to nutrition and physical activity, and make healthy meals available in the cafeteria;
- To monitor the effectiveness of the project over time.

Implementation

The Nutrition Department conducted a survey on the weight of hospital employees at the end of 2007 to identify the prevalence of excess weight and qualify workday eating habits. In 2009, a detailed version of the questionnaire will have been distributed to all hospital employees. In 2010, a training course on "Nutrition and Health" will have been organized for hospital staff.

Evaluation and results

The project was published in the Proceedings of the Nutrition Conferences, the hospital's newsletter and the SIO journal (Italian society for obesity). It will soon be published in *ADI Magazine* (Italian association of clinical nutrition). Moreover, in 2008, the project won the "Oliviero Sculati" award.

Source: Hospital of Santa Maria Nuova of Reggio Emilia, 2009–2010 projects inventory.

Project

Description nº 23

My Health and Me

Project	"My Health and Me" a Fun Active Living Initiative for Hospital Staff
Institution	G. Gennimatas General Hospital of Athens (Athens, Greece)

Context

The idea for this program arose from a desire to offer hospital staff a program that would support their needs for physical activity, work stress reduction, and on-site group staff activities, with the ultimate goal of creating a better working environment for them. The program was developed collaboratively between the hospital manager and the hospital's newly established Health Education and Prevention Office, which is run by a registered nurse specialized in health promotion and health education. To create the program, a needs survey was conducted among hospital staff at the very start of the program. The program design was finalized after taking into consideration the needs expressed by the hospital staff. The program could not have been implemented if the hospital manager had not shared the enthusiasm and the goals of the entire program and offered moral and financial support for the program.

Objectives

- Promote on-site physical activity for the hospital staff;
- Target work stress through on-site group activities that would help hospital staff manage stress levels (e.g. dance lessons, chess lessons, gym participation) as well as improving the work climate for staff;
- Support healthy diet and weight control for staff through an increase in physical activity and nutritional support;
- Achieve 10% hospital staff participation in the program within its first year of operation.

Implementation

The hospital's Health Education and Prevention Office, in collaboration with the hospital manager, initiated a health promotion program for the entire hospital staff whose aim was to increase the physical activity of the staff, while at the same time reducing work stress among this population. The project involved six hours per week of dance lessons, a one-hour weekly chess lesson, and the creation of a hospital exercise facility, which, it must be said, did not exist in any hospital in Greece at that time. To determine the activities to be offered, a staff survey was conducted, resulting in the ranking of a number of suggested activities (all targeting a behaviour change toward more physical activity, a reduction in stress and improved nutrition). In order to link the program to other health behaviour changes, nutritional support was offered to all staff who were registered with the hospital gym. To evaluate the program design on an ongoing basis, interviews were conducted with staff registered for the above-mentioned activities. Complementing the program targeting health education, the Health Education and Prevention Office published a staff newsletter that discussed such topics as health promotion and the advantages of behaviour change.

Evaluation and results

The targeted 10% participation rate among hospital staff was achieved in the first year of the program's implementation.

Success factors

- The determination and innovative spirit of the hospital manager in supporting health education and health promotion activities;
- Hospital management's financial support and allocation of space for the program;
- The existence of the Health Education and Prevention Office and the Health Promotion Specialist within the human resources of the hospital;
- The fact that the program was a first among Greek hospitals boosted the enthusiasm for it and stimulated an innovative spirit and the implementation of effective communication strategies;
- Free participation in the program for the targeted population.

Source: G. Gennimatas General Hospital of Athens, 2009–2010 projects inventory.

Project

Description nº 24

Fitness Centre

Project	HHS Fitness Centres
Institution	Halton Healthcare Services (HHS) (Oakville, Canada)

Context

In 2005, a satisfaction survey was completed by the staff at all three HHS hospital locations, the results of which clearly identified the priority of opening fitness centres especially for staff, volunteers, and physicians in order to improve staff health and well-being within the organization. As each fitness centre was being developed, a steering committee comprising potential users (staff, volunteers and physicians) helped to guide the design and selection of equipment. Following the opening of each fitness centre, surveys were completed to ensure that the users were satisfied and identify ways of improving the centres.

Objectives

- Open an on-site fitness centre at each of HHS's three hospital sites;
- Offer free use of the fitness centres to HHS volunteers, staff and physicians;
- Create fitness centres that address the individual needs of the users at each site;
- Survey and measure user satisfaction at each site;
- Offer a variety of schedules and types of fitness classes as well as literature at each fitness centre.

Implementation

In March 2005, the first HHS specific fitness centre was opened at the Milton District Hospital site, in line with responses and suggestions received from a staff satisfaction survey. In November 2006, a fitness centre was opened at the Oakville-Trafalgar Memorial Hospital site, and in September 2009, a third and final fitness centre was opened at the Georgetown Hospital site. Staff, volunteers and physicians have access to their gym 24 hours a day, seven days a week in such a way that all schedules, whether regular or irregular, are accommodated. There are no user-fees, as the gyms were opened and are maintained by corporate budgets. Each fitness centre was designed based on input from potential users in order to address the specific needs of the staff, volunteers and physicians at each HHS site. Each gym has a variety of fitness equipment, such as cardio equipment, free weights, and universal weight machines, as well as one or more personal trainers who come in to hold fitness classes on a regular basis.

Success factors

- Allocated corporate funding, enabling free membership for users;
- Champions within each site who promote the facilities;
- Collaboration with the staff at each site with regard to the maintenance of the fitness centres;
- Offering a variety of equipment and classes in order to reach all staff, physicians and volunteers;
- Listening and responding to the needs of the staff at each site;
- Maintaining around-the-clock access to the fitness centres, every day of the year.

Source: Halton Healthcare Services, 2009–2010 projects inventory.

Project

Description nº 25

Six-Week Non-Smoking Challenge

Project	Six-Week Non-Smoking Challenge
Institution	Montreal Sacré-Cœur Hospital (Montreal, Canada)

Context

This initiative was conceived following government amendments to the *Non-Smokers Health Protection Act*. One such amendment stipulated a nine-metre smoke-free zone around all entrance doors at healthcare institutions, which came after the banning of employee use of smoking areas. The complete closure of the smoking areas followed shortly thereafter. As some employees had difficulty complying with these rules, and the employer was required to take disciplinary measures (suspension without pay), it was felt that it would be beneficial to support employees by helping them quit smoking. As the hospital was involved in a public health program to screen for users who smoke and offer them alternative options to help them quit smoking, the hospital felt it was a good idea to likewise offer a smoking cessation program to staff.

Objectives

> Support employees who smoke and also wish to quit smoking;
> Reduce the number of staff who smoke;
> Improve the quality of life and well-being of employees.

Description

This project was first launched in May 2007 and has since been renewed on a biannual basis. During each challenge, an initial communication phase consists of informing staff about the program, its goals, and the dates of the next challenge. This is followed by a registration phase that runs several weeks in advance of the start of the non-smoking challenge, wherein participants contact an administrative officer in the Human Resources department to sign up for the challenge. Approximately one week before the start of the challenge, an information session for participants is organized jointly by Human Resources and the smoking cessation intervention team. This team comprises a pulmonologist, a respiratory therapist specializing in smoking cessation, a psychologist, and a nurse. During this meeting, the team members take turns speaking about the effects of smoking, alternative methods of nicotine detoxification, and motivators available to them to help them succeed in the challenge. During this first meeting, the pulmonologist is also available to make prescriptions, discuss the side effects of the various nicotine replacement therapies and offer support to participants.

At a second meeting, participants discuss their experiences, the obstacles they've encountered in trying to quit, and their successes. On this occasion, a number of employees who previously participated in this program come to share their experiences with the participants. At the end of the challenge, a third and final meeting takes place. As a reward for their efforts, a prize draw is held for all participants. Those who did not succeed in the challenge are invited to continue their efforts and sign up for the next challenge. It is also important for them to understand that, for some people, several attempts are necessary before finally succeeding in quitting smoking.

Evaluation and results

The success rate after five challenges is 36.6%.

Success factors

The creation of a program team and guaranteed follow-up by team leaders throughout the six weeks.

Source: Montreal Sacré-Cœur Hospital, 2009–2010 projects inventory.

Project

Description nº 26

Organizational Well-Being and Instruments for Reconciling Work and Family

Project	Organizational Well-Being and Instruments for Reconciling Work and Family
Institution	Health Services Regional Agency (APSS) (Trento, Italy)

Context

The APSS is a service organization. By creating a better working environment, the performance and services provided will improve. Attention must be paid to people's personal as well as professional lives.

- Female employees represent 69.5% of total staff;
- Services are provided 24 hours a day, 365 days a year;
- In Italy, women assume the main responsibilities for the management of the family;
- A reconciliation of work and family = same rights for men and women.

Description

Day nursery

- Pedagogical project focusing on the needs of children and of parents/employees;
- Location near the largest hospital in the province;
- Opening hours: 6:30 a.m. – 9.30 p.m. Monday through Saturday, all year round, with no summer breaks;
- Children go to the day nursery during their parent's shift.

***PerLa Project* (Personalization of working hours and teleworking)**

- Use of individual agreements signed by the employee and by the direct superior;
- Sharing of personal working hours with colleagues and mediation between the service needs and personal needs;
- Assuring the availability and quality of the service;
- Telecommuting: applies only to activities that can actually be carried out at a distance using communication technologies.

Evaluation and results

- Improvement in the working environment and in organizational well-being;
- Improvement in the quality of life of workers in terms of reconciliation of work and private life (work–life balance) and professional fulfillment;
- Improvement in performance and quality of services provided.

Source: PowerPoint presentation at the 18th International Conference on Health Promoting Hospitals and Health Services (HPH), Manchester, April 2010: «Organizational well-being and instruments for reconciling work and family»

www.hphconferences.org

Project

Description nº 27

Healthy Work Without Barriers

Project	Healthy Work Without Barriers
Institution	Women's Health Centre FEM Sud (Vienna, Austria)

Context

This is the first workplace health promotion project in Austria focusing on women's specific needs, including cultural and migration issues.

Target group is cleaning staff in hopitals – a multicultural group that is often socially disadvantaged and in which one frequently finds low education levels.

Since May 2006, the project has run at six hospitals in Vienna.

Objectives

> To raise women's awareness of health and healthcare issues;
> To improve workplace satisfaction;
> To empower the target group;
> To improve physical, psychological and social health.

Strategies employed

> A questionnaire concerning lifestyle and working conditions in four languages;
> Multilingual, gender-sensitive health circles adapted to the target group;
> An advisory board to secure sustainability at the executive level;
> Individual health promotion through special courses for the target group;
> Structural changes in the work process;
> Designation of one person per institution as the person responsible for health.

Description

Health improvement courses:

> Physical training such Pilates, Nordic walking, and gymnastic exercises for the spine;
> Stress management, conflict management, nutrition;
> Social counselling.

Structural changes:

> Optimization of work process;
> Introduction of housekeeping staff meetings;
> Optimization of information flow;
> Optimization of holiday planning.

Evaluation and results

> The participatory nature of the health circles in the employees' mother tongue resulted in their being very well received;
> Common health issues (i.e. smoking, nutrition, etc.) did not turn out to be the main issues for the target group;
> Psychosocial problems seem to be the most important issues;
> Health promotion is a management challenge.

Source: PowerPoint presentation at the 18th International Conference on Health Promoting Hospitals and Health Services (HPH), Manchester, April 2010: «Healthy work without Barriers – Intercultural and gender sensitive workplace health promotion for cleaning staff in hospitals »

www.hphconferences.org

Project

Description nº 28

Creative Recruiting of New Client Care Attendants

Project	Creative Recruiting of New Client Care Attendants
Institution	Canadian-Polish Welfare Institute Inc. Long-Term Care Centre (Montreal, Canada)

Context

In the context of a shortage of care personnel such as client care attendants, organizations have had to rely on private employment agencies to ensure sufficient staffing levels. However, this is a very expensive solution. The Canadian-Polish Welfare Institute was faced with the added challenge that the majority of its residents are of Polish or Ukrainian origin. It was thus important that the care personnel be able to communicate with the residents in their native language. Client care attendants being difficult to find as it is, the added language criterion rendered the task of recruiting even more complicated.

Management was aware that there were recently arrived Slavic immigrants who were seeking employment and did not have the financial means to attend courses. The centre's management thus decided to offer these individuals an opportunity to receive free training in Polish to become client care attendants.

Objectives

> Recruit new client care attendants in order to bolster the on-call list;
> Ensure a sufficient number of client care attendants during annual holidays;
> Avoid having to call on the costly services of private employment agencies;
> Recruit client care attendants who are knowledgeable about Slavic cultures.

Implementation

Management called on the services of a graduate nurse on its staff who was a certified attendant trainer and had previously trained new client care attendants. She was put in charge of the theoretical component. Management then established an agreement with a private training school to collaborate on the clinical component of the training. This school agreed to share this responsibility and issue certificates to those trainees who successfully completed the course. The sharing of responsibilities led to a reduction of over 50% in the training fees charged by the school.

Strategies employed

For existing employees:

> Modified schedule for the nurse who gave the training;
> Regular acknowledgement of the client care attendants who agreed to be paired up with new attendants.

For future employees:

> Free training;
> Training offered on the organization's premises (on-site);
> Possibility of employment following the training;
> Employee support—one of the Institute's core values—was provided to all new employees from the outset, which fostered greater employee commitment and allegiance to the Institute.

Project

Description nº 28 (cont'd)

Creative Recruiting of New Client Care Attendants

Evaluation and results

> 12 new client care attendants available/added to the on-call list;
> No shortage of attendants during the annual holiday periods during the summers of 2008 and 2009;
> No need to call on the services of private agencies, thereby enabling the Institute to keep its costs within budget;
> All of the client care attendants recruited had an enhanced understanding of Polish and other Slavic cultures.

Success factors

> Awareness of the difficulties faced by new immigrants;
> Ability to recognize immigrants' talents and knowledge;
> Training offered free of charge;
> Collaboration and commitment of multiple partners;
> Availability of financial resources enabling the course to be offered at no charge;
> Availability of a nurse who was certified to train attendants;
> Practical location for the training (on-site);
> Possibility of employment following successful completion of training.

Source: The Canadian-Polish Welfare Institute Inc. Long-Term Care Centre, 2009–2010 projects inventory.

Project

Description nº 29

Waste Management at the Philippine Heart Center

Project	Waste Management
Institution	Philippine Heart Center, Philippine Children's Medical Center and San Lazaro Hospital (Manila, the Philippines)

Context

In the past several years, the handling and management of hospital waste in the Philippines has been a hot topic among the population, particularly since incineration was banned in the country. It is estimated that Philippine hospitals generate 10,290 tonnes of waste annually. Before incineration was prohibited, the common practice was to burn hospital waste materials.

Objective

To improve hospital waste management.

Strategies employed

> Installation of yellow bins only in the areas where infectious waste is generated;
> Clear labelling of various biomedical waste containers;
> Installation of colour-coded bins and garbage containers for the various types of waste;
> Allocation of spacious areas to store recyclable materials;
> Rinsing of plastic and metal containers before their disposal in the designated storage areas;
> Composting of food waste.

Evaluation and results

> Reduction in the quantities of infectious waste as well as the costs associated with treating this waste: 490 kg produced in January, 2004; 95 kg produced in December of that same year;
> In 2003, the sale of recyclable, non-biodegradable waste earned one of the hospitals US$7,165;
> Sale of all or a portion of food waste to hog farms.

Success factors

> Support from senior management;
> Support from Health Care Without Harm;
> Staff involvement.

Source: Practices in Health Care Waste Management: Examples form Four Philippine Hospitals. (2007) Health Care Without Harm Asia.

www.noharm.org

Project

Description nº 30

Management of Residual Materials at CSSS de la Montagne

Project	Management of Residual Materials
Institution	CSSS de la Montagne – CLSC Côte-des-Neiges (Montreal, Canada)

Context

In 2003, the Côte-des-Neiges site of CSSS de la Montagne conducted an audit of its waste materials. This study enabled the centre to know where it stood with respect to the recovery targets of the 1998–2008 Quebec Residual Materials Management Policy (QRMMP). In 2006, thanks to support from the members of its green team, the CLSC achieved a 64% waste recovery rate. Although this was below the 80% QRMMP target, this data was nonetheless less encouraging, particularly since few other health centres in Quebec have gathered this type of information.

Objectives

> Recover 80% of the recyclable materials produced annually by the centre;
> Achieve the following waste recovery rates:
  – 70% of plastics, fibres (paper and cardboard) and wood;
  – 95% of metals and glass;
  – 60% of biodegradable waste.

Strategies employed

> Conversion of office garbage bins into paper recycling bins;
> Replacement of office garbage bins with smaller four-litre models;
> Negotiation of a mixed paper-cardboard collection contract with Cascades Inc., a recycled paper producer;
> Increase in the number of 360-litre paper recycling bins on each floor of the CLSC (as part of the contract signed with Cascades Recovery);
> Acquisition of two 360-litre recycling bins from the City of Montreal for the collection of plastics, glass and metals;
> Purchase of approximately 10 mini-bins for the collection of used batteries;
> Communication activities:
  – Articles in the internal newsletter;
  – Information booths;
  – Colourful posters on the recycling and garbage bins.
> Annual audits conducted in 2005 and 2006.

Evaluation and results

> In summer 2006:
  – 64% of recyclable materials were recovered;
  – The following waste recovery rates were achieved:
    – 93% for paper;
    – 99% for cardboard;
    – 48% for plastic, glass and metal.

Success factors

> Support from senior management;
> Presence of one person in charge of environmental issues;
> Involvement of members of the green team in identifying problems, proposing solutions, and communicating information to the CLSC's employees.

Source: Étude de cas: mise en place d'un système de gestion des matières résiduelles au CLSC Côte-des-Neiges [Case study: implementation of a waste management system at the Côte-des-Neiges CLSC] (2005).

www.recyc-quebec.gouv.qc.ca

Project

Description nº 31

Water Conservation at Milton Hospital

Project	Water Conservation
Institution	Milton Hospital (Massachusetts, United States)

Context

This is a good illustration of how small changes can make a big difference. The replacement of one faucet in the Milton Hospital kitchen resulted in a considerable reduction in the water consumed for dishwashing, while at the same time easing the work of employees tasked with this responsibility.

Objective

Reduce water consumption.

Strategies employed

> Installation of a foot pedal-operated spray rinser on the kitchen's pot scrubbing sink;
> Investment of US$240.

Evaluation and results

> Investment payback and savings earned in less than one month;
> Annual savings of US$3,300 (water and sewage costs);
> Annual savings of 370,000 gallons of water;
> Improvements to the rinsing process.

Success factors

> Support from senior management;
> Very minimal financial investment;
> Involvement of staff members.

Source: Water Conservation Checklist: Hospitals/Medical Facilities, North Carolina Department of Environmental and Natural Resources, August 2002.

www.p2pays.org

Project

Description nº 32

Water Conservation at Carney Hospital

Project	Water Conservation
Institution	Carney Hospital (Massachusetts, United States)

Context

Carney Hospital decided to reduce its water consumption by taking action in two areas: the refrigeration and air conditioning units, and the faucets in the examination and patient rooms.

Objective

Reduce water consumption.

Strategies employed

> Incorporating the refrigeration and air conditioning units into a recirculating closed-cooling loop;
> Installation of flow control fixtures on the faucets in all examination and patient rooms;
> Investment of $29,000 for the air conditioning and refrigeration units and $12 per sink for the patient and exam room faucets.

Evaluation and results

Air conditioning and refrigeration units:

> Payback on investment and savings earned within 18 months;
> Annual cost savings of US$20,000 (water and sewerage costs);
> Annual water savings of 3 million gallons;

Faucets:

> Investment payback and savings achieved in less than one month;
> Annual cost savings of US$280 per sink (water and energy costs);
> Annual savings of 32,000 gallons of heated water.

Success factors

> Support from senior management;
> Involvement of laundry department employees in decisions regarding the changes to be implemented.

Source: Water Conservation Checklist: Hospitals/Medical Facilities, North Carolina Department of Environmental and Natural Resources, August 2002.

www.p2pays.org

Project

Description nº 33

Water Conservation at CSSS de Chicoutimi

Project	Water Conservation
Institution	CSSS de Chicoutimi – Chicoutimi Hospital (Chicoutimi, Canada)

Context

The Chicoutimi hospital needed to upgrade its laundry equipment and replace the operating room air conditioners with ventilation systems.

Objective

Use the renovation project as an opportunity to implement water-saving processes.

Strategies employed

> Updating the equipment in the laundry department: replacement of conventional washing machines with a tunnel washing system;
> Replacing the water-cooled condensers with cooling towers for the operating room ventilation systems.

Evaluation and results

> Five-year return on investment as well as actual and estimated savings of CA$232,000 per year for the entire laundry facility project, including $36,000 per year in energy savings;
> For each kilogram of laundry washed, eight litres of water were saved;
> By the end of the two projects, an annual water savings of 100,000 m^3 is expected.

Success factors

> Support from senior management;
> Excellent collaboration from the regional health agency;
> Involvement of laundry department staff in decisions regarding the changes to be implemented.

Source: website of the Health and Social Services Agency of the Saguenay-Lac-Saint Jean region

www.d4m.com/soluss/developpement_durable (in French only)

Project

Description nº 34

Green Construction at Providence Newberg Medical Center

Project	Green Construction
Institution	Providence Newberg Medical Center (Oregon, United States)

Context

From the moment the decision to build the Providence Newberg Medical Center was made, the desire to obtain LEED certification was front and centre in the minds of those in charge of the project. Indeed, the hospital's senior management firmly believes in the relationship between environment and health. As such, building the hospital to the highest possible environmental standard was never in question.

Objectives

> Gold level LEED certification;
> Reduced building energy consumption;
> Improved quality of life for the facility's users.

Strategies employed

> 100% of electricity needs to come from clean energy sources (50% wind, 25% geothermal, 25% hydroelectric)
> Occupancy sensors and other lighting control systems to turn off lights in unoccupied rooms;
> Optimizing the use of natural light in all public spaces and waiting rooms.

Evaluation and results

First hospital in the United States to earn Gold LEED certification.

Success factors

> Initiative led by senior management;
> Goal of obtaining LEED certification was stated from the outset of the project;
> Close collaboration with the construction team.

Source: "Providence Newberg gets green – and gold! New medical center is "greenest" hospital in the nation." Hospital press release, August 8, 2006.

www.providence.org

Project

Description nº 35

Green Construction at Alès Hospital

Project	Green Construction
Institution	Alès Hospital (Alès, France)

Context

Alès Hospital added a new building to its facilities in 2010. From the earliest stages of the project, the hospital's administration expressed a desire to build a green facility that would be in harmony with its environment and healthier for its employees and patients. Their efforts paid off, as Alès Hospital became the first healthcare institution in France to obtain High Quality Environmental Standard (HQE) certification.

Objectives

> High Quality Environmental Standard certification (HQE);
> Reduced energy consumption;
> Improved water conservation;
> Improved quality of life for the building's users.

Strategies employed

> Optimizing the use of natural light in rooms and offices;
> Each room to have a view of the outdoors;
> Respecting the natural curves of the landscape to minimize environmental disturbance;
> Preserving the site's vegetation, notably in the parking lot;
> Wood heating (gas and oil as a backup);
> Multi-directional exterior sun-shading devices;
> Water-saving devices;
> Green roofs.

Evaluation and results

First healthcare institution in France to be entirely HQE certified in 2010.

Success factors

> Support from senior management;
> Demonstrated will to obtain HQE certification from the outset of the project;
> Close collaboration with the construction team.

Source: Un exemple de démarche volontaire de développement durable: construction du nouvel hôpital d'Alès. [*An example of a voluntary sustainable development undertaking: construction of the new Alès Hospital.*]

www.ch-ales.fr (in French only)

Project

Description nº 36

Green Construction at CSSS Lucille-Teasdale

Project	Green Construction
Institution	CSSS Lucille-Teasdale – CLSC de Rosemont (Montreal, Canada)

Context

Due to poor air quality in the building occupied by the CLSC de Rosemont, the senior management of the CSSS Lucille-Teasdale decided to move the CLSC to a brand new building to be built in Montreal's Angus Technopole. The construction team seized this opportunity to take all necessary measures to achieve Silver level LEED NC (new construction) certification (pending at the time of writing).

Project objectives

> Silver level LEED NC certification;
> Reduction in energy consumption;
> Improvement in the quality of life for the building's users.

Strategies employed

> "Green" parking lot: grassed-in lot with white roof to mitigate urban heat island effects;
> High-efficiency ventilation system that can generate an energy savings of over 30%;
> Low-flow plumbing and bathroom facilities that can generate water savings approaching 50%;
> FSC-certified wood in over 50% of the building materials;
> Less that 5% of construction waste to be sent to landfills.

Evaluation and results

> First CLSC in Quebec, Canada to achieve Silver LEED NC certification (pending);
> Predicted energy savings of over 30%;
> Predicted water savings approaching 50%.

Success factors

> Support from senior management;
> Demonstrated will to achieve LEED certification from the outset of the project;
> Close collaboration with the construction team.

Source: *Premier CLSC certifié LEED-NC Argent au Québec* [First Quebec CLSC to achieve Silver LEED NC certification], Novae, July 2010.

www.novae.ca

Project

Description nº 37

No More PVC!

Project	Green Procurement: No More PVC!
Institution	Lucile Packard Children's Hospital (Palo Alto, United States)

Context

In 2001, the Lucile Packard Children's Hospital decided to eliminate PVC from its intravenous systems. Why target PVC? Because it contains DEHP, a phthalate used to soften PVC (20–30% of its weight, and 80% in the case of tubing) that can leach out of PVC medical devices and have harmful effects on human health. Several regulatory bodies, including the Environmental Protection Agency (EPA) in the U.S., are working to warn people of the toxicity of DEHP and gradually phase out PVC and phthalates from the healthcare sector.

Objective

The goal of this pilot project was to reduce the presence of PVC in the hospital.

Strategies employed

> Take advantage of a contract renewal for intravenous products to seek alternatives;
> Collaborative work with all of the stakeholders involved in the change;
> Introduction of precise criteria to exclude PVC products;
> Purchase of PVC-free intravenous products.

Evaluation and results

> Annual cost savings of US$200,000;
> Positive effects on children's health (unspecified).

Success factors

Involvement of staff affected by the change.

Source: Lucile Packard NICU Makes Major Strides to Remove DEHP and Saves US$200,000 by Switching to Custom-made DEHP-free IV Product.

www.noharm.org

Project

Description nº 38

No More Mercury!

Project	Green Procurement: No More Mercury!
Institution	Philippine Department of Health (the Philippines)

Context

The WHO and Health Care Without Harm are leading a joint international campaign to eliminate mercury-containing thermometers and sphygmomanometers in the coming decades and replace them with appropriate and inexpensive alternatives. The goal is to reduce the demand for mercury-containing thermometers and sphygmomanometers by 70% by 2017.

Before 2005, the dangers of mercury in healthcare facilities were unknown in Southeast Asia. The first Southeast Asian conference on mercury was held in Manila in 2006. It was at this event that the Philippine Secretary of Health proposed to eliminate mercury from all hospitals in the country.

Objective

The objective is to reduce the demand for mercury-containing thermometers and sphygmomanometers by 70% by 2017.

Strategies employed

> Signing of Administrative Order 21, which stipulates the gradual phase-out of mercury from all Philippine healthcare facilities and institutions by 2010;
> Investment of CA$300,000 in the purchase of mercury-free thermometers through the 2009 General Appropriation Act.

Evaluation and results

In 2009, over 50 healthcare facilities in the Philippines (out of 1,900) had either eliminated or were in the process of eliminating mercury-containing products.

Success factors

> Government involvement;
> Involvement of healthcare facilities.

Source: Mercury-free Healthcare Philippines: Guide to Alternatives for Healthcare Personnel

www.noharm.org

Project

Description nº 39

Dairy Product Request for Proposals

Project	Green Procurement: Pilot Project – Dairy Product Request for Proposals
Institution	Regional group purchasing organization for the healthcare institutions of Saguenay – Lac-Saint-Jean (CRAG) (Chicoutimi, Canada)

Context

In 2005, CRAG managers began reflecting on the network's social responsibility with respect to the sustainable development of the community. As part of a management exercise, CRAG was mandated to conduct a pilot project to apply the principles of sustainable development to a request for proposals for milk.

Objective

The goal of this pilot project was to evaluate how the principles of sustainable development could be applied to the purchasing process; specifically, with respect to the procurement of dairy products for the healthcare institutions of the Saguenay-Lac-Saint-Jean region of Quebec, Canada.

Implementation

> Involvement of numerous network representatives;
> Involvement of external consultants.

Strategies employed

> Up to 10% preference margin for suppliers that demonstrate sustainable development practices;
> Consideration of a number of criteria in the awarding of the contract:
  - Supplier has sustainable development recognition or certification (1%);
  - Place of origin of end products (4%):
    - Same region as the receiving facility(ies) (4%);
    - Neighbouring region of the receiving facility(ies) (3%);
    - Same province as the receiving institution(s) (2%);
    - Neighbouring province or state of Quebec (1%);
    - Other or no response (0%).
  - Location of storage (4%):
    - Consideration of the economic situation of the company's host territory;
    - Seasonally adjusted unemployment rate;
    - Location of the end products' final storage facility.
  - Environmental standards (1%): regardless of the size of the company, the supplier must provide a document attesting to its participation in one of the following programs:
    - Programs recognized for small and medium-sized entreprises;
    - Programs funded by Environment Canada (e.g. Enviroclub);
    - Federal programs for distributors: ecoFREIGHT or ecoENERGY;
    - Programs funded by National Research Council Canada;
    - Programs funded by Hydro-Québec (e.g. energy efficient products program);
    - Programs funded by provincial recycling agency, Recyc-Québec (e.g. Phoenix of the environment);
    - Programs funded by the provincial government;
    - ISO 14000 Standard.
  - Environmental violations (-2%): this criterion aims to subtract two points from all companies, regardless of size, that have received a fine of more than $2,000 for a violation of the *Canadian Environmental Protection Act, 1999* (CEPA, 1999) within the past two years.

Evaluation and results

> This was a very interesting exercise, but it must evolve in line with the specific sustainable development strategy laid out by the government;
> The application of this exercise will have to be adapted according to the negotiation dossier;
> Certain declarations by suppliers are made on a voluntary basis and an officially recognized verification mechanism does not currently exist.

Success factors

Involvement of the relevant suppliers.

Source: www.d4m.com/soluss/developpement_durable

Project

Description nº 40

Shared Transport of Patients

Project	Sustainable Transportation: Shared Transportation of Patients
Institution	Des Feuillades Functional Rehabilitation Centre, Sibourg Convalescent Centre, and Parc Rambot Polyclinic (Aix-en-Provence, France)

Context

In 2008, three healthcare facilities in the Aix-en-Provence region of France conducted a shared transport pilot project for patients receiving regular care at each of the three facilities.

This initiative was beneficial on two levels:

> Environmental: by driving three patients at a time instead of one, the drivers save two return trips, and thus significantly reduce CO_2 emissions. The savings in fuel are also reflected in the health insurance budget;
> Social: as expressed by patient volunteers themselves, this measure fosters social contact and the creation of bonds with other patients, which in turn reduces anxiety associated with treatment.

Objectives

> Streamline patient transportation;
> Generate health insurance savings without compromising patient care.

Strategies employed

As agreed by patients, the shared transportation of patients who have appointments at around the same time of day at the same treatment centre.

Evaluation and results

> Rates of shared patient transport in 2008:
  – 30% for the Sibourg centre;
  – 55% for the des Feuillades centre;
  – 40% for the Parc Rambot polyclinic.
> 40% cost reduction for shared patient transport (€12 per person);
> Reduction in health insurance costs (€36 for three people travelling together compared to €60 for three people travelling separately);
> If this system were to be extended to all of France, it would represent a savings of between €30 and €40 million per year.

Success factors

> Partnership between three healthcare centres in the same region;
> Positive response from patients.

Source: Transports sanitaires en partage – Fondation Nicolas Hulot [Shared transport in healthcare – Nicolas Hulot Foundation]

www.fondation-nicolas-hulot.org (in French only)

DVD (in French only): Vers un monde de la santé: des pratiques vertueuses au service de la santé (Comité pour le développement durable en santé) [Toward a healthy world: virtuous/honourable practices in the name of health (Committee for sustainable development in the health sector)].

Project

Description nº 41

The “Access-Bike” Program

Project	Sustainable Transportation: The “Access-Bike” Program
Institution	CSSS de la Montagne (Montreal, Canada)

Context

In 2006, this CSSS was seeking ways to improve the health of its employees, reduce its ecological footprint and set an example. It soon became clear that by addressing the issue of employee transportation, the centre could achieve all three objectives at once. The centre’s catchment area lent itself particularly well to the use of bicycles for professional travel (e.g. home visits, inter-site travel).

Objective

Provide employees with a free bicycle rental service, which they can use for professional or personal travel during working hours.

Strategies employed

> Purchase of 18 bicycles to be made available to employees for their professional or personal travel during working hours;
> Target gorup: professionals who conduct home visits.

Evaluation and results

> Number of different users per season: 41 in 2006, 27 in 2007, 39 in 2008 and 44 in 2009;
> Number of rentals per season: 168 in 2006, 328 in 2007, 338 in 2008, and 424 in 2009;
> Winner of the 2008 Bicycle Friendly Organization Award from Vélo Québec.

Success factors

> Support from senior management;
> Expertise from a local transportation management organization, Mobiligo;
> Involvement of the person responsible for environmental management at the CSSS;
> Positive response from employees.

Source: CSSS de la Montagne.

Project

Description nº 42

"GO GREEN" Transportation Program

Project	Sustainable Transportation: "Go Green" Transportation Program
Institution	Maisonneuve-Rosemont Hospital (Montreal, Canada)

Context

In 2002, the Maisonneuve-Rosemont Hospital decided to implement the "Go Green" Transportation Program. Precursor to the city's "Allégo" initiative, this program distinguished the hospital by directly targeting the quality of work life as well as attraction and retention of its employees.

Objectives

Improve quality of work life and attract and retain personnel.

Strategies employed

Incentives offered to employees who abandon solo commuting in favour of carpooling, public transit, or active transportation (bicycle, walking);

- For public transit:
  - Discounts of up to 23.33% on the cost of a monthly pass;
  - Direct automatic payroll deduction.
- For carpoolers:
  - Preferential parking spots with reserved parking signs, closest to entrances.
- For cyclists:
  - Access to lockers and showers;
  - Ample spaces to park bicycles free of charge;
  - Enclosed and locked indoor parking space for more expensive bicycles.
- For all participants in the program:
  - Three taxi vouchers per year valued at a maximum of CAD$20 each for use in emergency situations;
  - A full-time resource person available on-site to address employee transportation needs.

Evaluation and results

- More than 15% of staff participated in the program;
- Multiple benefits to users: reduction in stress associated with traffic congestion, reduction in the risk of traffic accidents, time savings owing to the dedicated lanes for buses and carpoolers, financial savings, improved physical fitness, improved concentration at work;
- Hospital received Special Mention in the 2007 Énergia contest of the Quebec association for energy management (AQME).

Success factors

- Support from senior management;
- Involvement of a transportation coordinator;
- Positive response from employees.

Source: Association québécoise pour la maîtrise de l'énergie [Quebec association for energy management]

www.aqme.org/Accueil.aspx (in French only)

www.maisonneuve-rosemont.org

Project

Description nº 43

Energy Efficiency

Project	Energy Efficiency
Institution	Oregon Health and Science University's Center for Health and Healing (OHSU) (Portland, United States)

Context

The Center for Health and Healing was built according to LEED standards and was subsequently awarded the prestigious Platinum LEED certification. The facility's administration used this construction project as an opportunity to implement advanced energy efficiency design strategies.

Objective

Use the construction of a new facility to design a building that needs significantly less energy to operate than a typical building of this type.

Strategies employed

> Occupancy sensors to automatically turn off lights when there is no movement in the room;
> A Trombe wall, which passively absorbs daytime solar energy in a wall of highly insulated material and then transfers the heat at night;
> Window blinds that protect from the sun and also contain solar panels to produce electricity;
> Natural gas cogeneration plant that produces 35% of the building's energy needs.

Evaluation and results

> OHSU is 61% more energy-efficient than the average building in Oregon;
> Reduction in annual CO_2 emissions by 2,300 tonnes, the equivalent of 443 fewer vehicles on the road;
> The 2010 Outstanding Building of the Year Award (TOBY Award from BOMA International);
> Energy Star rating (2008);
> LEED Platinum (2007).

The TOBY Award from BOMA International recognizes excellence in building management and operation. The selection criteria include impacts on the community, energy management, accessibility for disabled people, emergency measure procedures, maintenance staff training programs and the overall quality of the building.

Success factors

> Political will of the mayor of Portland;
> Involvement of senior management;
> Close collaboration between the construction teams and the technical services team.

Source: (in French only) *Guide des pratiques vertueuses 2010.* [2010 Guide to Virtuous Practices.], Comité pour le Développement Durable en Santé.

Project Description nº 44
Energy Conservation

Project	Energy Conservation
Institution	Sir Jamshedji Jeejeebhoy Hospital (Mumbai, India)

Context

The Sir J.J. Hospital is one of the largest (1,352 beds) and oldest (150 years) hospitals in Southeast Asia. The agency responsible for the hospital's operation and maintenance implemented an awareness campaign to motivate staff to reduce their energy consumption.

Objective

Obtain energy savings using simple, "no- or low-cost" measures.

Strategies employed

> Raising awareness among employees about the benefits of energy conservation and energy efficiency;
> Maximizing usage of natural light during the day;
> Turning off office equipment, fans and air conditioners during unoccupied hours;
> Plugging air leakages in air conditioned rooms, such as offices and operating theatres;
> Turning off the water pumps once the tanks are full.

Evaluation and results

> Total cost savings of approximately US$90,000 over 2002, 2003 and 2004;
> Total energy savings of 812,000 kilowatt hours.

Success factors

> Support from senior management;
> Involvement of staff members.

Source: Promoting an Energy-Efficient Public Sector: Case Studies, Energy Conservation Awareness Drive at Sir J.J. Hospital Mumbai, India.

www.pepsonline.org

Project

Description nº 45

Energy Efficiency at CSSS Richelieu-Yamaska

Project	Energy Efficiency
Institution	CSSS Richelieu-Yamaska – Honoré-Mercier Hospital (Saint-Hyacinthe, Canada)

Context

As part of a large-scale renovation project at the Honoré-Mercier Hospital, the facility had to proceed with a complete overhaul of its building envelope. The CSSS thus seized the opportunity to implement advanced energy-saving designs.

Objective

Reduce the building's energy consumption.

Strategies employed

Complete evaluation of efficient heating, air conditioning and lighting control systems.

Installation of systems and equipment to optimize energy savings in all targeted areas:

- Enthalpy wheels and run-around coils that recover heat from air exhaust;
- Heat-recovery chillers;
- High-efficiency boilers;
- Efficient lighting systems;
- Low-temperature heating loop.

Evaluation and results

- Investment payback within 3.3 years, thanks to annual savings achieved as well as the four following grants:
  - Gaz Métro: CAD$97,771;
  - Programme IIE (Initiative des Innovateurs Énergétiques) de l'Office de l'efficacité énergétique: CAD$243,787;
  - Commercial Building Incentive Program (CBIP) from Natural Resources Canada: $60,000;
  - Hydro-Québec: CAD$359,508.
- Cost savings estimated at CAD$921,855 per year compared to the energy consumption of conventional HVAC systems;
- 37.5% reduction in energy consumption;
- Annual reduction in CO_2 emissions by 3,576 tonnes, the equivalent of 1,117 fewer vehicles on the road;
- Awards and special mentions granted to this project:
  - **"Énergia 2007"**, Buildings category – Institutional section, granted by the Quebec association for energy management (AQME), Special Mention;
  - **"2007 Quebec Consulting Engineer Grand Prize"**, Mechanical/Electrical Building category, granted by the Quebec association of consulting engineers (AICQ);
  - **"2007 Award for Excellence in Canadian Consulting Engineering"**, Buildings category, granted by the Association of Consulting Engineering Companies Canada (ACEC) and the publication *Canadian Consulting Engineer*;
  - **"ASHRAE Technology Awards 2008"**, Health Care Facilities, Existing Buildings category, granted by the American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE).

Success factors

- Commitment of the hospital's senior management to a strategy of energy efficiency;
- Involvement of the entire team of the Technical Services and Laundry Services Departments;
- Grants received.

Source: Association québécoise pour la maîtrise de l'énergie [Quebec association for energy management] www.aqme.org/Accueil.aspx (in French only)

www.canadianconsultingengineer.com/issues/story.aspx?aid=1000215426&type=Print%20Archives

bookstore.ashrae.biz/journal/download.php?file=nichols0308.pdf

Conclusion

Beyond being a practical and useful tool, we hope that this Guide provides you with information on the components that are fundamental to a healthy workplace promotion program: a participatory process using an integrated, multi-strategy approach that is aligned with the institution's orientations. These factors constitute the cornerstone of this Guide, around which all of the various themes revolve.

The involvement of users in decisions regarding their treatment options is strongly endorsed. Similarly, the participation and investment of employees in healthy workplace promotion programs is indispensible in any healthcare setting. Our workplaces must become pleasant working environments that foster professional and personal fulfillment as well as encouraging and facilitating the adoption of wholesome lifestyles. Healthy workplace programs must be implemented in keeping with shared global values, such as the reduction of social inequalities in health in the workplace and adherence to sustainable development principles.

In this way, over and above increasing employees' overall productivity, our workplaces will succeed in attracting future generations of workers and be in a position to recruit and retain competent and motivated individuals who have a desire to develop professionally within the healthcare system.

Today, it is important that all of us realize the positive ramifications that a healthy workplace approach can bring. Such a re-examination of our organizational priorities is critical and must be conducted with the maximum benefit of all staff and users in mind.

Agence de la santé
et des services sociaux
de Montréal
Québec