Hamilton Health Sciences

OFFICE OF STUDENT AFFAIRS

Learner Orientation Handbook

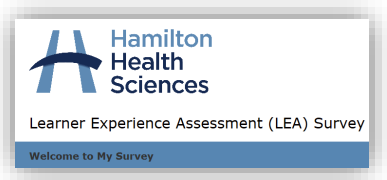
July 2019

Table of Contents

Page

Welcome to Hamilton Health Sciences

We look forward to your placement at Hamilton Health Sciences. We hope you will find this placement to be a valuable learning experience. Learning is a mutual responsibility between you and your supervisor. You should be identifying your learning needs and goals, i.e. what do you want to learn during your placement? Always feel free to ask questions and clarify things you do not understand.



Hamilton Health Sciences seeks to create excellent learning environments with our academic partners. In order to improve the student experience, we are seeking your feedback. Your opinion matters! If you recently had a learner / student placement at any of the Hamilton Health Sciences sites, kindly take a few minutes to complete the survey-> https://www.surveymonkey.com/r/LearnersMatter

We appreciate how valuable your time is and thank you, in advance, for completing this survey.

This booklet is designed to support your orientation to Hamilton Health Sciences. Depending upon the type of placement, you will receive orientation from the professor/ instructor, preceptor/supervisor and/or placement coordinator.

We wish you great success in your placement at Hamilton Health Sciences. Should you have any questions, please discuss them with your supervisor.

You are this Hospital

You are what people see when they arrive at
Hamilton Health Sciences.

Yours are the eyes they look into when they're frightened
and lonely.

Yours are the voices people hear when they ride the elevators,
when they try to sleep, and when they ask for help.

You are what they hear on their way to appointments
that could affect their destinies,
and what they hear after they leave those appointments.

Yours are the comments people hear,
when you think they can't.

Yours is the smile that warms them, and show the care
that they hoped they'd find here.

No patients, visitors, or co-workers can know how you care
~ unless you let them see it.

All they can know is what they can see,
and hear, and experience!

Show how *you* care!

At Hamilton Health Sciences, we are the care *you* give,
the attention *you* pay, the courtesy *you* extend.

Patient Relations/Risk Management

Extension: 75240

This is what we heard from our patients and families:

As a patient I ask that you always...

Communicate
with *compassion*

- Introduce yourself and your role to me.
- Make me feel welcome when I approach you. Smile. Look at me. Say "welcome to..." or "how can I help?" If I'm lost, please walk me to where I need to go, don't just point.
- Inform me about my care plan and daily activities.
- Stop. Look and listen to me.
- Respond promptly and courteously to my questions or concerns. If you don't know the answer, please find someone who does.

Collaborate
with *compassion*

- Include me and those important to me in decisions about my care, in a way I can understand.
- Get to know me and care about me as a person, by asking about my interests and preferences.
- Say "here is what we can do for you..." instead of what you can't.
- Speak positively about the people who work here.

Respond
with *compassion*

- Answer my call bell promptly. If you can't help me, please find someone who can.
- Follow through on what you said you would do.
- Initiate gestures of compassion to show me you care.
- Apologize for problems or inconveniences.

Patient and Family-Centred Care | Doing What Matters Most

Hamilton Health Sciences

Office of Student Affairs

The Office of Student Affairs is a central office which provides a coordinated, consistent student placement process across Hamilton Health Sciences for local, provincial, national and international students. It provides a central intake and resource office for students seeking placement at Hamilton Health Sciences. We are interested in receiving feedback from you regarding your learning experience at Hamilton Health Sciences. Please complete the evaluation form about your experience with us. These forms are available from your professor/instructor, preceptor/supervisor or the Office of Student Affairs. Please feel free to contact any staff with the Office of Student Affairs with your questions about your placement.

Staff	**Contact** 905-521-2100
Manager, Student Affairs & Academic Relations	ext. 46248
Office of Student Affairs	ext. 46245
Dietetic Education Coordinator	ext. 44923
Respiratory Therapy Clinical Coordinator / Associate (Fanshawe and Conestoga colleges)	ext. 73835

An Introduction to Hamilton Health Sciences

Hamilton Health Sciences is the largest provider of comprehensive healthcare in Ontario. It is governed by one Board, has one management structure and one medical staff.

Hamilton Health Sciences was created through the merger of Hamilton's two largest hospital corporations - Chedoke-McMaster and Hamilton Civic Hospitals - continuing a proud tradition of excellence in health care since 1846. Our family of hospitals includes: Chedoke, Children's, Hamilton General, Juravinski Hospital and Cancer Centre, McMaster University Medical Centre, St. Peter's and West Lincoln Memorial.

After approvals from the Ministry of Health and the Ministry of Consumer and Commercial Relations, Hamilton Health Sciences was officially created through Letters Patent on November 28, 1996.

Hamilton Health Sciences is an independently governed academic health science organization funded primarily through transfer payments from the province of Ontario's Ministry of Health.

Legal partnership agreements include Faculty of Health Sciences, McMaster University and Mohawk College Affiliation Agreements and a Collaboration Agreement with St. Joseph's Hospital, Hamilton. Hamilton Health Sciences now provides management services to West Lincoln Memorial Hospital, Grimsby, and Groves Memorial Community Hospital, Fergus. Hamilton Health Sciences serves as the "CEO" of these hospitals and over time will assume a greater role in the provision of services to them.
The management contracts provide opportunities for greater administrative and clinical efficiencies while maintaining independent governance by the respective hospital Boards.

Clinical Programs and Services

Hamilton Health Sciences provides very specialized healthcare to the 2.2 million people in Hamilton and Central South Ontario. From Oakville to Burlington and Niagara to Fergus, we are the referral hospital for such specialties as Acute Children's Services, Cardiology and Cancer Care. These programs provide a critical mass of expertise and a home for other core health services such as Orthopedic Surgery, Neurosciences, Emergency Medicine, and Rehabilitation to name a few. Our hospitals are also community hospitals for the people of Hamilton.

Programs

- Acute Inpatients, Emergency, PICU and Pediatric Ambulatory
- Autism, Child & Youth Mental Health, Developmental Pediatrics & Rehabilitation, Audiology
- Cardiac, Vascular and Infection Prevention and Control
- Diagnostic Services
- Laboratory
- Medicine, Emergency and Juravinski Cancer Centre
- Mental Health and Addictions
- Neurosciences
- Perioperative Services and Medical Device Reprocessing
- Regional Rehabilitation, Complex Continuing Care and Seniors' Health
- Systemic, Supportive and Regional Cancer
- Surgical Services, Critical Care and Orthopedics
- Trauma, Medicine and Emergency
- Women's Reproductive Health, Neonatal Intensive Care Unit and Adult Ambulatory Care

Mission

To provide excellent health care for the people and communities we serve and to advance health care through education and research.

Vision

Best care for all.

Values

Hamilton Health Sciences' values and behaviours are defined in the following four values with their associated values-based behaviours:

Respect
- We treat every person with dignity and courtesy.

Caring
- We will act with concern for the well being of every person.

Innovation
- We will be creative and open to new ideas and opportunities.

Accountability
- We will create value and accept responsibility for our activities.

Goals

- To provide an excellent patient experience for all.
- To be world leaders in moving evidence into practice to deliver the best patient care.
- To be leaders in driving change to achieve a seamless healthcare system.
- To be a leader in attracting and stewarding resources to advance our mission.
- To be the organization of choice for talented people.

Hamilton Health Sciences

Visit our intranet page at: http://corpweb/strategy

Values-Based Code of Conduct

A values-based code of conduct provides a set of expectations regarding behavioural standards that benefit staff, learners, physicians and volunteers by creating healthy work and learning environments. The Hamilton Health Sciences Values-Based Code of Conduct is based on our organizational Values, particularly RESPECT. The basic principle is to treat others the way you would like to be treated. It is the responsibility of each member of HHS to listen to each other and work collaboratively.

Each of us must take ownership and accountability of our own behaviour in the work and learning environment. All members of HHS are equally responsible for abiding by the Code including employees, medical/professional staff, board members, contract staff, volunteers, learners, and students. Regardless of position, we are all empowered to respectfully address inappropriate behaviour we experience or observe.

Inappropriate behaviour includes:

* Verbal comments about or directed to an individual that are insulting, hurtful, disrespectful, rude, degrading, demeaning, threatening or abusive
* Profanity or similarly offensive language
* Physical behaviour that is perceived as threatening, intimidating or unwelcome
* Body language that is irritating or offensive
* Discussion of workplace conduct, concerns or conflicts in front of others
* Passive-aggressive behaviour where there is aggressive or malicious intent masked by passive behaviour

Helpful words or phrases:

* "I do not appreciate how you are saying that to me."
* "This is not the place to discuss this."
* "It is hard for me to understand when you are yelling at me – can we try it again."
* "I think we need someone to help us work through this issue."
* "I understand you are upset – what can I do to help?"
* "We do not seem to be getting anywhere. Let's take a break and come back to discuss this later."

There is a five-stage resolution process designed to empower individuals who observe or experience inappropriate behaviour to address it in a direct and respectful manner. The individual is responsible for stages 1-3 and the Manager is responsible for stages 4-5.

Stage 1: Direct Communication
If you experience or observe inappropriate behaviour, you are encouraged to speak directly, respectfully and privately to that person.

Stage 2: Seek Assistance
If the issue cannot be resolved by speaking with the individual or if you are uncomfortable speaking with the person directly, you are encouraged to seek assistance from a neutral third party. A peer or your preceptor may be able to help to develop a strategy for speaking with the individual.

Stage 3: Seek Coaching
If you require further support, you may wish to speak with your Faculty member or an HHS staff member including the Clinical Manager, Education Clinician, Preceptor, Placement Coordinator, or other member of the Office of Student Affairs. This individual can provide coaching assistance to you in order to develop an appropriate approach to resolving the issue.

Stage 4: Manager Response
At this stage, the Manager initiates appropriate action within one week of being notified of the inappropriate behaviour. Additional individuals, such as the Chief, Interprofessional Practice or Practice Leader, may become involved at this stage. The Manager must gather facts by meeting with both parties and any witnesses, determine what must occur in order to resolve the issue, and then outline expectations of the individuals involved.

Stage 5: Progressive Discipline
Before steps are taken toward progressive discipline, the Manager must consult with Human Resources and/or the Chief, Interprofessional Practice or Practice Leader regarding staff or the Vice President Medical regarding physicians.

For more information on the Values-Based Code of Conduct, visit the Human Rights and Diversity Department webpage on the HHS intranet or call ext. 73475.

CHEDOKE • CHILDREN'S • GENERAL • JURAVINSKI • McMASTER • ST. PETER'S • WEST LINCOLN

Hamilton Health Sciences

Workplace Violence Prevention

Workplace violence is any act in which a person is abused, threatened, intimidated or assaulted in his or her employment. Unfortunately 50% of healthcare workers will be physically assaulted during their professional careers. Here are some definitions. . . .

Threatening behaviour involves shaking fists, destroying property or throwing objects.

Verbal or written threats involves any expression of intent to inflict harm including, **direct threats** (I'm going to make you pay for what you did to me."), **conditional threats** ("If you don't get off my back, you will regret it.") and **veiled threats** ("Do you think anyone would care if someone beat up the boss?").

Harassment involves any behaviour that is designed to trouble or worry the victim (including sexual, religious and racial), or coercive or fear-inducing behaviour.

Verbal abuse includes swearing, insults or condescending language.

Physical attacks include hitting, shoving, pushing or kicking.

Domestic violence occurs when a family member, partner or ex-partner attempts to physically or psychologically dominate another. This can affect the workplace directly or indirectly.

Resolving an issue when you experience or observe inappropriate behaviour can be a difficult and stressful experience. The following are some tips you can use to successfully communicate and resolve conflict.

Tips for difficult conversations

- slow down and take a deep breath
- get the facts – your story, their story
- listen carefully
- recognize emotions will be involved
- repeat what has been said
- develop options
- prevention techniques (see below)
- consider how this situation could be avoided in the future

Prevention techniques

- always deliver messages with respectful dialogue
- ask for a "time out" if the situation is escalating
- hear what is being said to you
- empathize if you can
- apologize when you can
- do not retaliate

How to intervene

- try to de-escalate the situation only if it is safe to do so
- a Code White may need to be called
- contact your supervisor or another staff member for assistance with the situation
- talk with your supervisor about the types of examples of violence in the workplace in your placement location
- know where exits or safe locations are located in your placement location in case you need to leave the situation
- know where panic buttons, alarms and telephones are located in your placement location

Some examples of violence in the workplace in a healthcare setting

A nurse receives a threatening phone call from a patient at her home. The nurse is concerned about her and her family's safety. She is concerned that because she received the call at her home that it would not be considered work related.

> Although this nurse received the telephone call at her home, this is still considered a workplace incident. The nurse should alert her manager immediately. A risk assessment and or strategy should be implemented in collaboration with hospital security.

A physician is upset with the slow pace in his operating room. In frustration he throws a surgical instrument at a team member in hopes of motivating her/him.

> If the patient is safe you should exit the situation and ask for assistance from your supervisor or security. Reporting this type of behaviour is imperative.

Your ex-partner works at the same site you work in. You have been receiving threatening phone calls, unpleasant emails and unannounced visits in your workplace. You are embarrassed and frightened with his escalating behaviour.

> When you are made to feel uncomfortable, embarrassed or frightened in the workplace there is a problem. You should seek assistance as soon as possible. If you are feeling threatened and/or frightened by someone's actions you can call Code White. If you are concerned about the potential of someone's comments or actions, please identify this to your supervisor, professor/instructor from your school, manager of the area in which you are placed or hospital security.

It is the responsibility of everyone within HHS to:

- acknowledge, read and uphold the HHS Values and Values Based Code of Conduct
- be aware that a Violence in the Workplace protocol exists
- provide a safe and non violent workplace
- be accountable for reporting whether you are directly involved or witness an act of violence
- participate in prevention of violence in the workplace education.

You will need to read the Violence in the Workplace protocol which is included along with other important policies and procedures for your review.

Mandatory Education:
WHMIS and Emergency Code Education

General and area specific WHMIS and Emergency Code education is required for your placement. If your school does not provide general WHMIS and Emergency Code education, you will need to complete a learning package. Area specific WHMIS and Emergency Code education is to be provided by the professor/instructor and/or preceptor/supervisor.

Contact the Office of Student Affairs with any of your questions about WHMIS or Emergency Code education.

Emergency Preparedness Overview

Introduction

The information below provides an overview of HHS Emergency Preparedness. All staff, students and affiliates should know:

- emergency code general principles
- emergency preparedness resources
- emergency code protocols and their roles/responsibilities

Students are expected to know the general principles, code notification process and actions to take in a Code situation.

Code Purple-Hostage Situation

On discovery… Do not disturb area, do not approach hostage-takers, or take unnecessary risks.

If taken hostage… Observe & gather info. **Stay** calm, courteous & cooperative. **Speak** when spoken to. **Establish** eye contact, but don't stare. **Avoid** doors & windows. **Attempt** escape only if certain.

On witnessing or escaping … Get away & alert others. **C**all code & give details i.e. (# & description of hostage-takers & hostages; # & type of weapons; Location; Threats or demands; if mobile, vehicle type & direction.

If code announced…Remain in place & direct others to do same. **C**lear hallways of persons. **C**lose all doors. **R**emain on alert until notified of "all clear" or directed otherwise.

Code Silver- Shooting or Active Shooter

On discovery or notification of a person threatening with or discharging a firearm, **flee, seek cover & warn/assist** others if able. **Call 911** on external phone line. If able, also call **x5555 (7777 @ SPH)** & report code. If unable, ask 911 operator to alert Hospital. If not safe to speak, leave line open & allow 911 operator to listen. Escape/evacuate area if able, keeping hands free, visible, raised & following any police instruction. If unable to escape safely, find a secure shelter, lock & barricade door. Turn off lights & any source of noise. Hide behind large items. Wait for Police or Security to arrive, identify themselves, provide verification or listen for "all clear" overhead. As a last resort, & only if your life is in imminent danger, incapacitate the shooter by acting as aggressively as possible.

Code Stage Terms

"Alert" is used if a code is uncertain & staff are to wait for further information.

"Standby" is used if a code is certain but there is time to prepare for the response.

"In-Effect" is used if code response is to be implemented immediately.

"All Clear" is used to direct staff to resume normal duties.

All office areas *are expected to follow code response plans as applicable.*

Area Code Staging Locations are usually nursing stations, reception areas, by exits or lobbies. ***Know yours or ask someone.***

Code Pocket Response Guide for HHS Staff & Medical Staff

On Discovery **of a Code …** notify area charge person if immediately available. If not, **call x5555 (7777 @ SPH) from hospital line or 905-521-2100 & ext above from outside line. Give name, site, exact location & details of code. Remain at scene unless unsafe.**

For all announced codes: **Listen** to announcement. **Go** to area code staging location for direction. **Avoid** elevator & phone use unless urgent or part of code response. Respect secured areas. **Carry** your ID badge. **Follow** the Area Charge Person's direction.

For more copies, see EDM Sharepoint

Code Black- Bomb Threat or Suspicious Object (1of 2)

If announced… Assemble in area code staging location for instructions & area search . *Do not participate in search if area unfamiliar*

On receipt of a phone threat:
Remain calm, courteous & listen .. Discretely ask staff to call in the code. Encourage caller to talk & repeat info: **Ask & record:**. **When** will bomb explode? **Where** is it located? **What** does it look like? **How** do we deactivate it? **Why** was it put there? **Who** is responsible for it? From **where** is caller phoning ? **Identify** caller # if able & **Caller Characteristics** Gender, ~Age, Voice: Accent, Diction, Manner; Familiarity; Background Noise. **Log** call time & duration

Code Black- Bomb Threat or Suspicious Object (2of 2)

If suspicious object discovered…
Avoid handling; **D**o not use radio/cell phone; **S**eal & leave scene undisturbed; **M**ove to safe location . **C**all Code

Handle mail with care & check for suspicious signs before opening.
If pkg/envelope OPENED & powder seen:
Avoid handling & put down carefully
Drape with plastic (e.g.garbage bag)
Wash hands thoroughly
Continue as for suspicious object

If person claims to have bomb…
Follow Code Purple as if taken hostage

Code Aqua- In-Facility Flood

On discovery of a flood (i.e. uncontrolled quantity of water believed to be a physical, health or env. hazard that can result in harm), call call **x5555 (7777 @ SPH)** & report code location; assess area for occupant safety (e.g. electrical hazard, ceiling integrity etc.) & need for evacuation; assess equipment safety & need to protect from damage (move or cover with plastic); secure & place spill barriers around affected areas to contain water. If appropriate & safe, unplug electrical equipment from power source. Assist with clean up if directed.

Code White- Violent Situation

If unable to de-escalate & manage safely, call or ask staff to call Code White: x5555 (7777 at SPH) state Code White, site & exact location. Keep agitated person in view and wait for responders.

Code Blue-Cardiac or Medical Emergency

Used for adult or child (patient, visitor or staff) with cardiopulmonary arrest, pre-arrest or other medical emergencies (i.e. severe distress, loss of consciousness), where pt's condition is beyond the knowledge, skills &/or judgment of surrounding staff.

*Note: **Pediatric Code Blue** is only called at MUMC as is **Code Pink** for neonatal babies from NICU, Level 2 Nursery and 4C babies*

On Discovery of code… Initiate basic life support if trained. Call or ask someone to call the Code (5555 or 7777 @ SPH) and activate a Code Blue switch if available. Remain at scene until response team arrives & follow their instructions.

Code Green- STAT or Precautionary/ Controlled Evacuation

A **STAT evacuation** occurs if an area is in immediate danger & requires urgent occupant evacuation. Use **HEAT*** if nec.

On announcement of Code Green Stand-by: Assemble in area staging location; Review evac plan & route. Follow Area Charge Person's directions: i.e. record all occupants, available & needed supplies, equip. & staffing; if time, assist with pt d/c or transfer.

On notification of Code Green In-Effect: Record & evacuate occupants in order directed to specified destination. If time permits, turn off equip. & gases, place tape across empty room door frames & corridor doors at knee level when last person leaves. On reaching destination, re-check attendance & await further direction.

Code Yellow – Missing Adult
Amber – Missing or Abducted Child or Infant

On notification of code… Assemble in code staging location. Review missing person description on EDM Sharepoint site code yellow/amber page. Conduct area search for missing person. Report negative area findings via online search and sweep report on EDM site or call 77753 if online report not available. Call 5555 (7777 @ SPH) to report person if found & location. Resume normal duties & remain on alert until "All Clear"

Note: With each Code Yellow stage escalation (Stage1,2,3) announced, an area search is to be repeated & positive findings reported

Code Orange External Disaster

On notification of Code Orange Standby: All staff on duty & going off duty are to assemble in their area code staging location for further direction from their Manager. A Resource Status Report is submitted to the Command Center. Patient areas submit patient discharge & bed & equipment status reports. If directed, fan-out procedure is initiated. Patient areas prepare to receive incoming or pt transfers from decanting areas. Non-patient areas prepare to support patient area resource needs e.g. supplies, equip, staff, services

On notification of Code Orange In-Effect: casualties have begun to arrive in the ED. Areas activate their area response plans & follow direction from their chain of command.

Code Brown-In-facility Hazardous Spill

On discovery of a hazardous spill (i.e. chemical, blood, cytotoxic drug or radiological) that cannot be contained or appropriately cleaned up by available resources. Notify Area Charge Person or dial x5555 (7777 @ SPH) & report type of spill type. Restrict spill area access before leaving scene.

On notification of code, avoid area until all clear announced.

Code Red - Fire or Visible Smoke

On discovery of fire or visible smoke **R-E-A-C-T**: **Remove** persons from room **Ensure** doors/windows shut. **Activate** nearest fire alarm. **Call** code red x5555 (x7777@SPH). **Try** to contain/extinguish if able. Ask nearby staff to help until Hospital Fire Response Team arrives. Use fire extinguisher & **P.A.S.S.**(Pull pin; Aim at base of fire; squeeze handle ; sweep from side to side keeping your back to an exit)

If unable to contain fire/smoke…
Close & place wet material under door. Clear corridor & exits. Begin to evacuate adjacent occupants & area to safe location. *Call Switchboard for **H.E.A.T**. activation (Hospital Evacuation Assistance Team) to area if needed.

On hearing H.E.A.T. announced: all areas are to deploy a staff member to the requesting unit for assignment from the requesting unit's Area Charge Person.

Code Grey – Infrastructure Loss

Used for loss of power, water, heating, ventilation, cooling, mmedical gas (O_2, medical air, nitrous oxide, nitrogen), medical vacuum, telecommunications or computer network failure. Also used if contaminated air enters hospital or area (e.g. internal or external noxious fumes) requiring a "button down"

On discovery of loss or noxious fumes in area, call x5555 (7777 @ SPH), give name, ext & describe situation, location of occurrence & priority based on safety issues.

If announced overhead, follow Area Charge Person direction & contingency plan if needed.

IF You SMELL SMOKE:

Search area, call x5555 & report smell of smoke, but not fire. **Do not activate fire alarm.** HHS Site Fire Response Team will investigate source & determine further action. *If at SPH, call SPH Switchboard, ask to notify Maintenance, or if after hours, Security.*

On Hearing FIRE ALARM:

Assemble in Area Code Staging location to log attendance & follow Area Charge Person directions i.e. Turn on lights & close all area doors. Clear corridors & exits.

Search area & report if fire/smoke present. Have fire extinguishers ready in case.

Security Services

Recommendations for a safe and secure environment:
As part of an ongoing effort to provide a safe and secure environment, staff and students should ensure that:

- Unoccupied and isolated work areas are secured.
- Lock up all personal valuables and equipment, example: purses, wallets, cell phones, laptop computers, and house and car keys.
- You and your colleagues or persons assigned to work in your area wear identification badges.
- In a safe and non-threatening manner, challenge persons who are in a restricted area or in any area after visiting hours, without appropriate identification. By simply acknowledging a "would be criminal's" presence, they will probably leave the area.
- Any suspicious persons or activity are immediately reported to Security Services. Suspicious activity includes anything which seems out of the ordinary for whatever reason.
- Actual or potential breeches in security including lost keys and access cards are to be reported to Security immediately.
- Items of value should be left at home. Do not bring in items of value or large sums of money to work.
- Never leave your personal property unattended.
- Make sure that your purse, briefcase, gifts, pager, cell phone, laptop computer or other items of value are not left in plain view. This creates an invitation to "would be criminals".

Remember…

ALL THEFTS MUST BE REPORTED TO SECURITY SERVICES

Although Security Officers patrol every area of the Hospital, it would be impossible for them to be at all places at all times. Educating and motivating all staff to be security conscious and responsible increases the hospital's security effectiveness substantially.

Security Services are an excellent resource to assist you in your security needs. If you have any questions or concerns, please feel free to call for assistance.

Our central number is 74444. You will be directed to on-site Security first, and then our control centre after five rings.

Employee Health Services

Chedoke
Wilcox Building, Room B04 (basement)
ext. 77081

General
4 North, Room 403
ext. 46307

Juravinski
Section A – Level 0 – Room A 0 60
(opposite staff elevators) ext. 42314

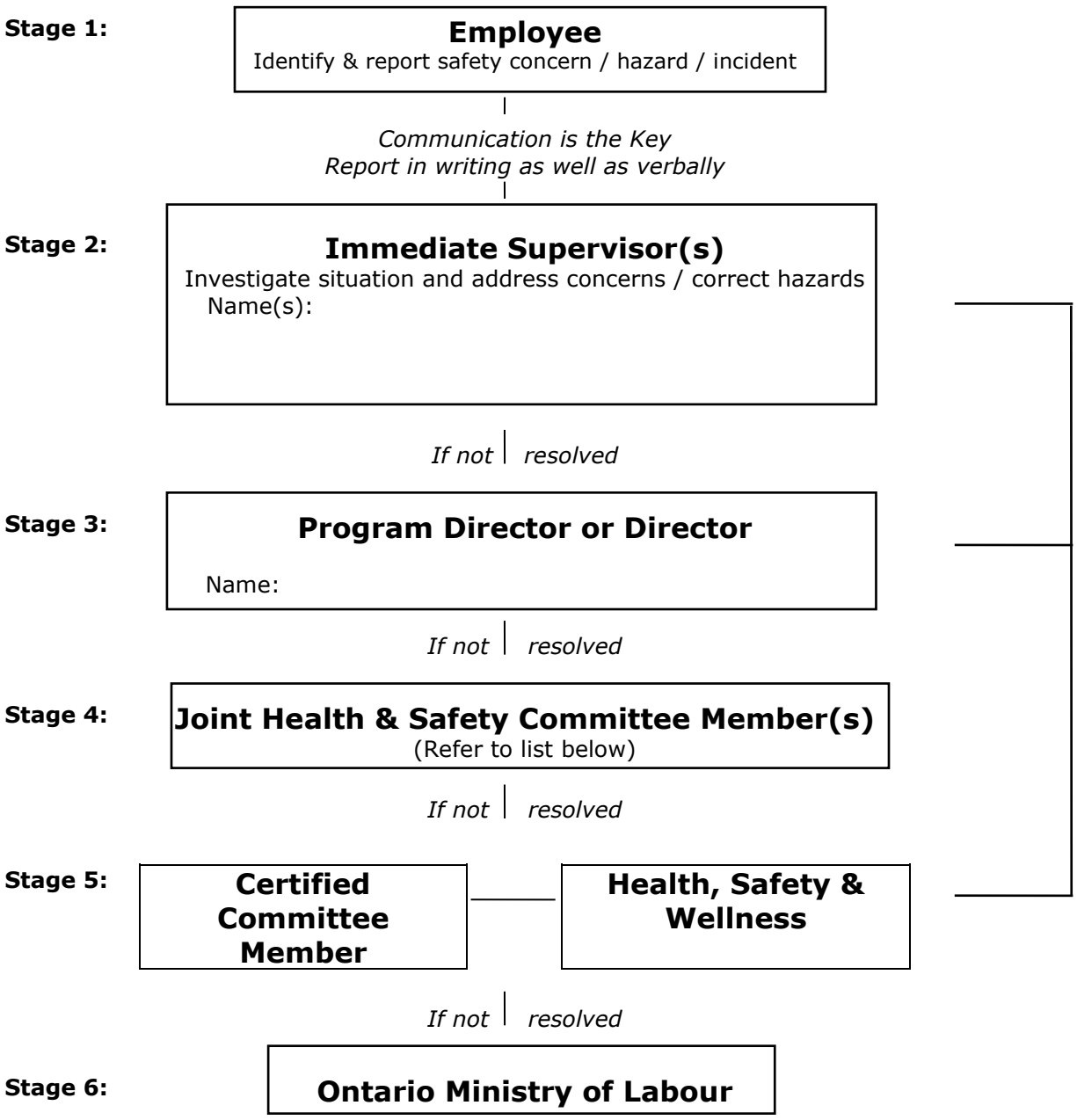
MUMC
Room 1F11 (1st floor, behind the red elevators)
ext. 75573

St. Peter's
Lower Level West
ext. 12204

West Lincoln Memorial
Basement - in Accounting Office
905-945-2253 ext. 211

If you are in need of immediate first aid due to an injury while working at Hamilton Health Sciences, please visit Employee Health Services or Emergency in off hours. Ensure your school is notified. Please speak with your professor/instructor and/or preceptor/supervisor to help you complete a Safety Occurrence Report.

OCCUPATIONAL HEALTH & SAFETY COMMUNICATIONS STEPS



JOINT HEALTH AND SAFETY COMMITTEE :

Worker Members				Management Members		
Rep For	**Name**	**Location**	**Ext.**	**Program**	**Name**	**Ext.**

Advisory Member:

Infection Control

Signage is in place at all entrances of the hospitals reminding everyone about healthy behaviours to prevent the transmission of infection diseases.

Please read the signage as you enter the hospital. Remember, handwashing is an important measure to reduce infection.

Please be aware that students are not to wear N95 masks unless they have been fit tested. Only selected groups of students are being fit tested based on their academic discipline and their placement location. Please direct any of your questions around mask fit testing to the Office of Student Education.

N95 masks are required for patients who are in Airborne Precautions or Droplet Contact Precautions plus N95 masks with potential infectious agents that are transmitted through the air. The most common reasons are tuberculosis, varicella (chickenpox) and pandemic influenza-like illness. N95 masks are also required for high risk respiratory procedures that generate aerosols such as suctioning, intubation, bronchoscopies, nebulized therapies etc.

Since SARS, new standards have been issued by the Ministry of Health and Long Term Care around dealing with respiratory illness. As part of these standards, all health care workers, including students, must report specific illnesses to their school's health service and the employee health service of their clinical site. The OMA/OHA Communicable Disease surveillance protocols for Ontario state:

Health care workers have a responsibility to their patients and colleagues regarding not working when ill with symptoms that are likely attributable to an infectious disease. This includes influenza-like illness, febrile respiratory illness, gastroenteritis and conjunctivitis.

Students with the following need to be assessed and report the following:

Rashes – There is a need to rule out measles or varicella (chickenpox). There are restrictions for working with these illnesses.

Diarrhea – If gastrointestinal illness occurs where the individual has nausea, vomiting and/or diarrhea and it lasts approximately 2-3 days, the likely pathogen is the norovirus. Norovirus is spread by contact and droplet transmission. Even after an individual is free from symptoms, the individual continues to excrete the virus for up to 48 hours. Work restrictions are required.

Febrile Respiratory Illness/Influenza-Like Illness - If you have a temperature over 38 degrees **AND** new onset or worsening of an existing cough **PLUS** sudden onset of any of the following symptoms:

- sore throat
- severe fatigue
- headache
- muscle pain
- joint pain

you need to remain away from your placement.

You can return to your placement:

- 24 hours after all symptoms have resolved, if you feel generally well other than a mild cough **OR**
- after 72 hours of taking Tamiflu, if you feel generally well other than a mild cough.

It is not uncommon to experience a persistent cough for days to weeks following a respiratory tract infection. If all other symptoms have resolved, you may return to your placement if you are still coughing.

If your placement is in a clinical area providing patient care **AND** you have symptoms of influenza-like illness, please call Employee Health Services before you return to your placement.

Currently Employee Health Services does **NOT** provide treatment for students. If you are from an out of catchment school located some distance away, you may be seen by Employee Health Services only if you are placed in a clinical area providing patient care **AND** have symptoms of influenza-like illness. Students from McMaster University and Mohawk College need to see student health services at their campus if they are ill.

Conjunctivitis – Anyone with "pink eye" must be assessed and cannot provide patient care until a diagnosis is made. Conjunctivitis due to bacterial pathogens responds quickly to antibacterial eye drops and the **student may return to clinical areas after 24 hours of effective antibiotic therapy.** However, if the conjunctivitis continues, it may be viral. Viruses such as adenovirus can cause an infection that lasts up to 6 weeks. Adenovirus is highly infectious. Antibiotics will not eradicate this organism and therefore work restrictions are necessary.

"HAPPY HANDS" at Hamilton Health Sciences

If you would like more information about the importance of hand washing in preventing infections, please speak with your professor/instructor, preceptor/supervisor and/or placement coordinator. They can direct you to the "Happy Hands Learning Package" available at Hamilton Health Sciences.

Why the concern?
The infections patients get while staying in the hospital are the 4th leading cause in death in Canada.

1/3 of these hospital acquired infections could be prevented by proper hand washing.

Some key points to consider about handwashing:
- Most infections are spread by direct contact with infected patients and/or objects and then passing the infection from our own hands to our self or our patients.
- Hand washing is something everyone can do to keep our patients and the community healthy.

Protect yourself:
- Most of the infections you have ever had, you have given to yourself by your own hands.
- Wearing rings and artificial nails results in constantly contaminated hands increasing you and the patient's risk of infection.
- Artificial nails are not allowed for anyone providing patient care or a food handler (Hamilton Health Sciences Policy).

To keep your hands clean wash often using waterless hand wash products (gels and foams) OR soap and water.

Waterless hand wash products (gels and foams) are recommended when:
- Hands are not visibly dirty
- Running in and out of patient rooms
- After handling patient equipment
- Before and after wearing gloves
- In-between cleaning of hands after each piece of Personal Protective equipment (PPE) is removed after procedures or when leaving isolation rooms

Soap and water are recommended when:

- Hands are visibly dirty
- Before and after touching patients
- After handling mobile medical equipment that has touched patient's skin or is contaminated
- Before and after breaks
- After using bathroom
- After blowing your nose or covering your mouth to cough
- After being in contact with organisms that produce spores. Spores cannot be killed off with any kind of soap, but they can be rinsed off with soap and running water.

Hand washing technique:

- Turn water on and adjust to comfortable temperature
- Wet hands then apply soap (minimum of 3ml of liquid soap or Gel or golf ball size of foam, is required for best results in hand washing)
- Using **FRICTION** rub hands, finger pads, in-between fingers, front and back of hands to wrists for 10-15 seconds (count or hum to ensure full 10-15 seconds of friction)
- **RINSE** hands well and go directly to paper towel dispenser
- Dry hands and with paper towel, shut faucets off with paper towel, discard used paper towel in waste basket

When in doubt… **wash your hands**!

Questions?

Please contact an Infection Control Practitioner (ICP).
Staff in your area can direct you the appropriate ICP.

Policies and Procedures

There are a few key policies and procedures that you need to read prior to your placement. Should you have any questions about these or other HHS policies and procedures, please speak with your professor/instructor or preceptor/supervisor.

Confidentiality of information concerning patients, visitors and staff is vital at HHS. Please be sure to keep this information confidential. Disclosure, misuse or failure to safeguard confidential information is subject to severe disciplinary action.

All students are expected to reflect an image that inspires the confidence of our clients and stakeholders. What you wear at school or during your personal time may not be appropriate here, e.g. spaghetti straps, bare midriffs and excessively tight, revealing or baggy clothing are not acceptable at HHS.

Cell phones, BlackBerries, two-way radios and other wireless devices must remain OFF in all areas of the hospital except lobbies, cafeterias, public hallways and business offices. In public areas, please keep cell phones, BlackBerries and other wireless devices at least 1 meter away from any medical device. Authorized two-way radios must remain at least 3 meters away from any medical device when keyed.

There is no smoking on hospital property effective January 1, 2011. There are three eLearning modules in the Breathe Easy Smoking Cessation Program. Each module must be taken in sequence. All three modules are for health professionals. The third module is specifically for RNs, pharmacists and physicians. Speak with your professor/instructor, preceptor/supervisor and/or placement coordinator for information on how to acces eLearning modules at HHS. Students with computer access can log on using guest access.

A few more details about the importance of confidentiality…

What is the difference between confidentiality and privacy?
Confidentiality refers to not communicating information, which is needed in the performance of a job. Privacy is not gathering information, which is not needed in the performance of a job. Depending upon the type of placement you are completing, you may have access to personal health information for patients for whom you are providing care and also to patients for which you are not part of the circle of care. It is vital that you access only information that is needed for you to do your work required for your placement. Accessing information that does not relate to your work will result in disciplinary action. Personal health information needs to be kept to the bare minimum of those who need to know in order to provide needed care.

What is personal health information?
Personal health information refers to information about a person in oral or recorded form about the person's physical or mental health, including the health history of the person's family that relates to the provision of that person's health care, including the identification of a person as a provider of health care to the individual. This information can also relate to payments or eligibility for health care or health care coverage; donation of body parts or substances; health number or identifying the substitute decision-maker.

What are the patient's rights regarding their personal health information?
Patients have the right to access their personal health information. Requests for access should be in writing and must provide enough information to identify and locate the record. Individuals have the right to withdraw consent for the collection, use and disclosure of their information for fundraising, teaching, notifying a religious representative, patient satisfaction surveys and confirmation of inpatient/room/status. Patients can also request to have their chart corrected if they believe it is not accurate. Again, a written request must be made. Hamilton Health Sciences reserves the right, through its policies and procedures to determine how the patient may access this information.

How can you help to ensure patient privacy and confidentiality?
It is vital that you protect information that you need to use as part of your learning experience at Hamilton Health Sciences. Be sure to always return charts to their proper location. Do not keep notes that contain the patient's name or other information that could identify the patient. If you have received a computer password for your placement, do not share it. Do not use anyone else's password. Again, it is vital that you access only information that is needed for you to do your work required for your placement. You are only to use your password for accessing information

about patients you are currently treating. Please also remember where you are when you discuss confidential information. Do not discuss confidential information in public places such as elevators, hallways, cafeteria and coffee shops, at home, etc. Although you should feel free to discuss your experience with others, make sure that you don't mention any information that could identify the patient. Please also keep in mind measures to protect the patient's privacy. Please be sure to knock before you enter a patient's room or close the curtain or bathroom door when assisting your patient. Be sure that patients are covered when moving through corridors. Should you have a smart phone, do not take pictures of patients or charts. Hospital charts are not to be photocopied either.

To learn more about privacy legislation in Ontario, visit www.gov.on.ca

FIPPA

What is FIPPA?

"FIPPA" is the Freedom of Information and Protection of Privacy Act, and it will affect hospitals as of January 1, 2012.

FIPPA provides people with a right to access information that is under the control of institutions in the public sector, such as universities and hospitals. There are four principles:

- Information should be available to the public.
- There should be exemptions to access of information and those exemptions should be limited and specific.
- Decisions on the disclosure of information should be reviewed independently of the hospital that controls the information.
- The privacy of individuals and their personal information should be protected by the institution holding the information and those individuals should be able to access that personal information upon request.

A record is any record of information however recorded, whether in printed form, on film, by electronic means or otherwise.

- Examples include: minutes of meetings, spiral notebooks, handwritten notes, etc.

Any person can make a request for access to records. A person includes individuals and organizations, such as the Hamilton Spectator.

- In addition, the right to access is not limited by citizenship or place of residence, i.e. an international student who has had a placement at HHS can request his or her record.
- A formal written request must be made in writing (not by phone) to the hospital where the person requesting the information believes the record exists. There are two types of formal requests – personal information or general access. There is a cost of $5 for each personal information or general access (such as the results of a Code Black exercise) request and this must accompany the written request.

FIPPA doesn't cover patient records, as these types of records are covered by a different law, known as QCIPA (the Quality of Care Information Protection Act).

- QCIPA covers quality of care information and is part of the work that the hospital's designated quality of care committee does. The information that this committee gathers reviewing quality issues would be considered exclusion under FIPPA and would therefore not be released if an FOI (freedom of information) request was made.
- There is another law, known as PHIPA (Personal Health Information Protection Act) that covers personal health information (PHI) in the patient record. Requests for information that deal with PHI will be covered under PHIPA and Freedom of Information requests that deal with QCIPA information will not be released.

Formal requests for information are handled by the HHS Privacy and Freedom Of Information Office. As an organization, HHS has only 30 days to respond to a Freedom of Information (FOI) request.

- If you receive a formal (written) FOI request in your area, contact the Privacy and FOI Office – IMMEDIATELY! Call extension 75126 or email FOI@hhsc.ca

Hamilton Health Sciences is legally obliged to protect personal information. Therefore, your personal information will not be released to anyone without your personal consent.

- Personal information is recorded information about a person and includes race, family status, employment history, education history, identifying numbers (such as student number, social insurance number), etc.

Remember the following principles when collecting personal information:

- You need consent to collect, use and share all personal information, either formally or informally (this includes sending information in email or posting pictures on the Internet, for example on Facebook).
    - This consent can be either direct (written) or indirect (verbal).
- All personal information should be collected with a consistent purpose in mind.
    - Collect the MINIMAL amount of personal information required to accomplish the task.
    - Collect what you need to do the job at hand.

- You should only access personal information that is required to perform the duties of your placement and for the purposes outlined on the **HHS Statement of Information Practices**.
- Safeguard all personal information.
- Consider the implications of technology:
    - Is it mobile, can and do you take it off hospital property, is it in an open public space?
    - If you need to take sensitive files out of the office, you must store them on an encrypted memory stick. Encrypted data cannot be read without knowing a key or password.

Remember, Hamilton Health Sciences is legally obliged to protect personal information. Therefore, your personal information will not be released to anyone without your personal consent. **To do otherwise would lead to a privacy breach and can potentially lead to a privacy complaint.**

- Privacy breaches occur when the hospital shares or discloses someone's personal information inappropriately.

If a breach occurs, **please notify your immediate supervisor and contact the Privacy and FOI Office, extension 75122 or email privacy@hhsc.ca**

Confidentiality Policy

Hamilton Health Sciences	*Human Resources*
Posting Date: 2011-01-13 **Posting History Date**: 1999-06-09, 2007-04-30	Page 1 of 2
HR – Confidentiality	

Applies to: All employees of Hamilton Health Sciences and Hospital Affiliates.

1.0 Purpose

Human Resources employ knowledge and practices in support of Hamilton Health Sciences (HHS) mission, vision and values. The policy establishes the expectations of our employees, the behaviours we seek and those we do not tolerate relative to the access and management of confidential information.

2.0 Policy Statement

2.1 Upon hire, all employees are required to complete and sign a "Confidentiality Pledge".

2.2 As an employee of HHS, all clinical or health related, personal, Human Resource, social and / or psychological information concerning patients, visitors and staff is held in strictest confidence; regardless of whether access to such information was verbal, documented, computerized or otherwise obtained. Employees divulge, obtain and/or use confidential information only as needed by them to perform legitimate duties of their job. Inappropriate access, disclosure, misuse or failure to safeguard confidential information is subject to severe disciplinary action up to and including termination.

2.3 Employees who cease employment with the HHS are expected to treat confidentially all information mentioned above, and agree not to disclose it to any third party, for any reason, except with written authorization from the hospital.

2.4 Computer Information/Passwords

2.4.1 Employees must protect any user code(s) or password(s) used to access computer information systems and programs. Employee user codes and / or passwords are the equivalent of their signature and all activities undertaken using such codes and passwords are the responsibility of the employee. If at any time the employee feels that the confidentiality of their code or password has been or might be breached, change the password / code promptly and report any concern to their supervisor.

2.5 Personal Health Information Protection Act

The HHS has incorporated the requirements of the Personal Health Information Protection Act into its policies and procedures for the access to and treatment of confidential patient and staff information. It is the responsibility of all employees accessing patient information to become familiar with and adhere to these provisions. Any fraudulent application, violation of confidentiality or any other violation of the above provisions may result in disciplinary action up to and including termination from employment, and/or, fines for liability under the Personal Health Information Protection Act.

3.0 Cross References

Employee Attitude and Conduct
Employee Identification Policy
Employee Records and Confidentiality of Employee Information
Internet Policy
Termination of Employment
Guidelines for Patient Care Notes
Employee Code of Conduct
Pledge of Confidentiality

4.0 Developed By

Compensation Associate

5.0 In Consultation With

Legal Counsel
VP of Human Resources
Manager, Human Resources
Human Resource Consultant
Relevant Employee Groups

6.0 Approved By

Vice President, Human Resources

Reviewed with Minor revisions by Manager, Human Resources December 2010

Fit for Work Policy

Hamilton Health Sciences	Page 1 of 4
Posting Date: 2019-07-03 **Posting History Dates:** **Next Review Date:** 2022-07-03	
Title: HS&W – Fit for Work	

Applies to: All HHS staff, Hospital Affiliates, members of the Medical, Dental and Midwifery staff and HHS patients and visitors

1.0 Purpose

1.1 This Policy describes the circumstances under which a physician, employee, student or volunteer (herein referred to as "individual(s)") may be required to undergo a fitness to work assessment and establishes expectations for reasonable behaviour as it relates to their ability to perform their workplace duties safely, competently and efficiently.

This Policy strives to respect the dignity and privacy of individuals; and places a priority on treatment, accommodation and successful recovery while ensuring the safety of patients and those individuals working, practicing and volunteering at HHS.

2.0 Policy

2.1 General Statements

Hamilton Health Sciences (HHS) is committed to the physical and mental well-being of individuals and ensures individuals that present with fit for work issues receive effective, fair and constructive support. This policy applies to all individuals while at work conducting hospital functions (whether at a hospital site or elsewhere).

An individual must be physically, medically and mentally fit to work. An individual shall not be allowed to work unless they maintain a fitness for work required for the safe performance of job functions, with or without reasonable accommodation. Each individual is required to report to work in a mental and physical condition (including free of the effects of alcohol and drugs, including both legal and illegal drugs) necessary to perform their work safely. An individual is expected to discuss with their leader and/or the Employee Health Nurse any circumstances that may impact their ability to do so.

An individual demonstrating observable difficulty performing their duties in a safe manner and/or posing a safety threat to self or others may be required to meet with their department leader to discuss their physical and/or mental capacities in order to determine their ability to perform essential job functions. Non-compliance may be cause for disciplinary action, up to and including termination of employment. In the case of physician non-compliance, corrective action may be taken through the reporting structure, i.e. department Chief up to the Medical Advisory Committee.

The individual's satisfactory work performance is the basis for continued work/practice at HHS. Participation in a treatment or rehabilitation program does not guarantee continued employment/ability to practice and may not necessarily prevent disciplinary/corrective action for violation of the hospital's policies. An individual may be required to provide proof of fitness to work from their health care practitioner following a Fit for Work discussion. In the event that an individual is referred for an evaluation and is pending approval to return to

work, applicable leave policies, practices and/or collective agreement requirements shall apply.

This policy does not apply to individuals with short term, infectious/communicable diseases (e.g. flu, colds), the Communicable Disease Protocol will apply.

Individuals who have the responsibility for on-call shifts must meet the fitness for work standard during the entire on-call period.

2.2 Roles and Responsibilities

2.2.1 **All individuals**: are responsible for understanding and abiding by this policy and related procedures. These procedures are aligned with expectations set by professional colleges and hospital by-laws. All individuals are responsible for knowing and understanding the personal and hospital liability for not taking action with respect to an Individual who is unfit for work.

2.2.2 **Employer:** HHS is responsible for providing safe and effective care and services for patients and a healthy, safe workplace for individuals ensuring their fitness for work and providing them with a suitable work environment. HHS is also responsible for reporting to the appropriate regulatory college or body when a regulated health professional is believed to be incompetent or incapacitated.

2.2.3 **Leader:** Each leader at HHS is responsible for communicating with individuals about the need to maintain a work environment that is free from substance use (except where permitted for medication) and any circumstances that may impact an employee's ability. This includes answering questions about this policy.

Leaders are also responsible for:

- Early and regular identification, documentation and management of performance issues that may be related to impairment of fitness by any cause including substance use and/or Substance Use Disorders, cognitive impairments from acute mental health conditions and their treatments in consultation with Human Resources;
- Encouraging individuals to engage in HHS's Accommodation Program should they disclose any concerns that their medical condition or treatment (without disclosing the diagnosis or treatment) including substance use and/or Substance Use Disorders, cognitive impairments from acute mental health conditions and their treatments may result in the individual being unfit for work and/or require any accommodation;
- Identifying and addressing situations where an individual appears to be unfit for work, which may include relieving an individual of their duties.
- In consultation with Human Resources, Employee Health Services and other stakeholders, participate in the accommodation and return to work process of individuals, where required.

2.2.4 **Individual:** Individuals working/practicing at HHS are responsible for attending the workplace fit for work and remaining fit for work throughout their entire workday (including individuals who participate in telecommuting arrangements and those on-call)

Individuals are also responsible for:

- Reporting to their leader concerns about whether another individual is fit for work, whether through witnessed behaviour or otherwise. Where the unsafe or questionable actions involve the leader, seek advice from Human Resources Services

- Consulting with their physician regarding any prescribed medication that may impact their fitness to work and requesting accommodation if required
- Being aware that the use of illicit drugs in the workplace, on HHS property or while engaged in HHS activities is strictly prohibited
- Refraining from the use, distribution, manufacturing, offering or selling of any substances while in the workplace, on HHS property or while engaged in HHS activities. On an exceptional basis, the use, distribution and selling of alcohol may be permitted where it is done as a part of an approved hospital funded hospitality event, and
- Refraining from diverting medications from HHS, the patient of HHS, or other HHS personnel

3.0 Definitions

Alcohol: The intoxicating agent in beverage alcohol, ethyl alcohol, or other low molecular weight alcohols including methyl and isopropyl alcohol. Beverage alcohol includes but is not limited to beer, wine, distilled spirits and very low alcohol products (e.g. beer with 0.5% alcohol by volume) as are included in this definition (*Ontario Ministry of Health).*

Fit for Work: An individual is able to perform the duties of the job with efficiency, competence and in a safe manner as compared to established or generally accepted performance standards.

Illicit Drug: Any drug or substance that is not legally obtainable by the individual and whose use, sale, possession, purchase or transfer is restricted or prohibited by Canadian law (which may include but is not limited to street drugs such as cocaine, heroin, hallucinogens, stimulants), and includes prescription drugs that have not been lawfully prescribed to the individual.

Impaired / Unfit for Work: The inability to safely, competently or efficiently perform work duties without limitation resulting from substance use, after effects of substance use or otherwise being under the influence of substances.

Individuals: All persons under the scope of this policy who carry out business for HHS including employees, physicians, volunteers, and students.

Leader: For the purpose of this policy the term "Leader" refers to: Supervisor, Manager, Director, Executive, Chief Medical Executive, Physician Chief, Medical Director, Physician Head, and Physician Lead.

Medication: A drug obtained legally, either over-the-counter or as properly prescribed by a registered and regulated health professional.

Misuse: The intentional use of medication in a way or for a purpose that was not intended or under circumstances that risks the health or safety of the individual, their co-workers and/or the workplace.

Non-Compliance: Failure to comply with any or all aspects of this policy and/or related policies.

Substance: Any substance that is ingested, consumed or otherwise taken, and includes alcohol, illicit drugs, marijuana and medication where the use of which represents a misuse of medication.

Substance Use Disorder: A primary, progressive, and chronic disease characterized by the regular, repetitive, habitual, compulsive, obsessive use of a substance or a combination of substances. Moderate to severe Substance Use disorder is characterized by a preoccupation with the substance(s), loss of control, increased tolerance to the substance(s), harmful consequences in one or more major life areas, denial and delusion.

Undue Hardship: The limit of the hospital's capacity to accommodate without experiencing an unreasonable amount of difficulty, as defined in the *Human Rights Code*.

Workplace: Any land, property, structures, facilities, premises, location, hospital vehicle and equipment owned, leased, operated or otherwise controlled by the hospital or any other place at, upon or from which an individual works in the course of their duties.

4.0 HHS Forms or Other HHS References

HSW - Substance Use Disorder (SUD)/Addictions Protocol & Other Addictive Disorders Protocol
IPC - Mandatory Reporting of Regulated Health Professionals to Regulatory Bodies Guideline - Incapacity Incompetence Sexual Abuse/Assault

5.0 External References

Ontario *Workplace Safety & Insurance Act*
Controlled Drugs and Substances Act
Ontario *Human Rights Code*
Ontario *Occupational Health and Safety Act*

6.0 Developed By

Manager, Health & Ability
Sr. Employee & Labour Relations Specialist

7.0 In Consultation With

Human Resources
Employee Health Services
Occupational Health Physician
Joint Health & Safety Committee

8.0 Approved By

Director, Health, Safety and Wellness

Keyword Assignment	Fit, fitness, safe, performance, safe performance

Footwear and Personal Protective Equipment Policy

Hamilton Health Sciences	Page 1 of 3
Posting Date: 2017-12-05 Posting History Dates: 2007-09-11; 2010-08-24; 2011-12-22; 2013-02-05; 2014-05-13; 2015-07-28; 2016-12-07 Next Review Date: 2018-12-05	
Title: **HSW - Footwear and Personal Protective Equipment**	

Applies to: All HHS staff including Medical, Dental and Midwifery Staff, Hospital Affiliates (Contract Staff, Volunteers, Learners) including the Juravinski Cancer Centre and McMaster Children's Hospital.

1.0 Purpose & Goals Description

To reduce the risk of accidents and injuries that may result from improper footwear or lack of appropriate personal protective equipment.

2.0 Equipment/Supplies

None

3.0 Policy

3.1 Footwear

3.1.1 Clinical Areas including their hallways and areas where there are biological, chemical and physical hazards, all employees must wear shoes that meet the following:

1. Heel height – low to medium (maximum 3") and appropriate for work performed
2. Closed toes and closed heel with a solid upper covering
3. Flexible non-slip soles
4. Sturdy construction
5. Shoe must be maintained in good repair
6. Staff wearing a walking cast (plastic walking boot or air casts or any other leg support) will be evaluated on an individual basis to ensure they are safe for the work being performed. Responding to emergency situations will be included in any accommodation necessary.
7. Any staff, including non-clinical staff, entering a clinical area must wear the appropriate footwear as outlined above

3.1.2 Clerical or Office areas shoes must have:

1. Heel height – low to medium (maximum 3") and appropriate for work performed
2. Sturdy construction
3. Flexible, non-slip soles
4. Shoes must be maintained in good repair

3.1.3 The following workers must wear approved footwear appropriate to the task:

1. Engineering - CSA
2. Stores/Shipping and Receiving - CSA
3. Any other worker based on a hazard analysis
4. CSA grade 1 footwear is required on construction sites.

3.2 Personal Protective Equipment (PPE)

3.2.1 Personal Protective equipment is used when there are no engineering or administrative controls available to eliminate or reduce the hazard.

3.2.2 When selecting personal protective equipment, the following factors are to be considered:

1. Provides adequate protection against the particular hazards for which it is

designed
2. Fits the worker properly to provide adequate protection
3. Limitations of the equipment have been identified

3.2.3 Personal protective equipment includes but is not limited to:
1. Safety boots or shoes
2. Safety glasses, face shields or goggles
3. Gloves (chemical resistant or other)
4. Fire retardant clothing
5. Hearing protection
6. Hard hats or bump caps
7. Respiratory protection
8. Impervious gowns and aprons

3.3 Responsibilities

3.3.1 **Director**

Ensure compliance to the policy.

3.3.2 **Manager/Supervisor**
1. Identify any potential hazards where PPE is required.
2. Identify and provide appropriate PPE to the worker according to the potential hazards.
3. Provide training on the care, use, storage and limitation of the PPE.
4. Maintain training records.
5. Replace equipment when required.
6. Designate the type of footwear to be worn in the department based on the provisions identified in the policy or on the hazards and safety requirements of your department.
7. Ensure workers comply with the required PPE and footwear requirements.
8. Initiate disciplinary procedures for non-compliance through HHS Progressive Discipline Policy.

3.3.3 **Worker**
1. Wear the designated PPE and footwear.
2. Participate in the training as required.
3. Inspect PPE prior to use and report any deficiencies.

3.3.4 **Health, Safety and Wellness**
1. Assist in hazard identification, equipment selection and evaluation of casts as required.

4.0 Definitions

Biological Hazards: related to organisms such as viruses, bacteria, fungi and parasites

Chemical Hazard: solid, liquid, vapor, gas, dust, fume or mist

Physical Hazard: potential for penetration of sharp objects, falling objects, carts/beds/ stretchers running over feet, heavy or mobile equipment in use such as pallet jacks,

forklifts, noise, vibration, high temperature, low temperature, radiations, etc.

Administrative controls: reducing/eliminating hazard exposure through task changes, scheduling, work practices or work location (i.e. job rotation, standard operating procedures).

Engineering controls: reducing/eliminating exposure by substituting, isolating or equipment modification (i.e. ventilation, safety engineered medical sharps)

Personal Protective Equipment: any additional protective device or clothing that meets approved standards that may be required to ensure the health and safety of workers during the course of their working hours.

5.0 **Cross References**

1. Health and Safety Policy Statement
2. Progressive Discipline

6.0 **External References**

R.S.O. 1990 Occupational Health and Safety Act
O. Reg. 67/93 Health Care and Residential Facilities
Canadian Standards Association Standard CAN/CSA Z195-02
O. Reg. 213/91 Construction Projects

7.0 **Developed By**

Health, Safety and Wellness

8.0 **In Consultation With**

Joint Health and Safety Committees
Manager, Human Resources
HR/ER Associates

9.0 **Approved By**

Director – Health, Safety and Wellness
Manager – Safety

Keyword Assignment	*Footwear, personal protective equipment, PPE, shoes, hazard, SAFEWORK, CROCS*

Fragrance Restricted Protocol

HAMILTON HEALTH SCIENCES	ADMINISTRATION MANUAL
Posting Date: 2008-10-02 **POSTING HISTORY DATES:**	PAGE 1 OF 4
Title: **CORP - Fragrance Restricted Protocol**	

Applies to: All individuals and groups who are in any way associated with the Hamilton Health Sciences workplace including employees, medical/professional staff, contract staff, patients, family members, volunteers, visitors, hospital affiliates and students (individuals).

1.0 Purpose & Goals Description

1.1 To provide guidelines and direction to promote a fragrance restricted environment at Hamilton Health Sciences.

1.2 To help prevent adverse reactions (asthma, headaches, nausea) for highly scent/fragrance sensitive individuals.

2.0 Equipment/Supplies

Appropriate signage
Fragrance Restricted Information Sheet

3.0 Policy

3.1 Fragrance restricted signage are to be visible at all entrance doors.

3.2 HHS is to continue to promote awareness of health concerns related to fragrance and scented products through the intranet and internet, signage, information packages or other written materials.

3.3 Appropriate printed patient materials should include information highlighting the hospital's fragrance restriction.

3.4 Individuals are encouraged to communicate any sensitivities related to fragrance to their managers.

3.5 Individuals are encouraged to respectfully (see Values Based Code of Conduct (VBCC)) advise others of excessive fragrance use, request that it be removed if possible, and request that it not be used at subsequent visits.

3.6 Non-compliance with requests to adhere to fragrance restriction are to be dealt with individually and as appropriate.

4.0 **Procedure VBCC Protocol**

4.1 **Stage 1 - Direct Communication**
When you experience or observe inappropriate behaviour, you are encouraged to speak directly, respectfully and privately to that person.

Stage 2 - Seek Assistance
If the issue cannot be resolved because you are uncomfortable speaking with the person directly or if the issue was not resolved when you did speak to the person, the assistance of a third party may be needed. Speaking privately to a peer or coworker you trust may help you develop strategies for speaking to the person about the issue.

Stage 3 – Seek Coaching from Manager, Supervisor, Chief of Professional Practice or Practice Leader
Your manager, Chief of Professional Practice or Practice Leader will provide coaching to assist in developing an approach to resolve the issue. If the person that has displayed the inappropriate behaviour is your own manager, you should seek assistance from the individual who supervises your manager.
In order to promote a healthy and enjoyable work environment, if the issue remains unresolved, it is important to proceed to the next stage.

Stage 4 – Manager Response
The manager initiates appropriate action within one week of being notified of inappropriate behaviour. If you are a Health Care Professional, your Chief of Professional Practice or Practice Leader may be involved at this stage. If the person that you have an issue with is your own manager, then you should seek assistance from the individual who supervises your manager. The manager meets with both parties and any witnesses to gather the facts. The manager documents the investigation process that includes statements from both sides and any witnesses involved. The manager determines what needs to occur in order to resolve the issue and outlines the expectations of the individuals involved. The manager may decide to intervene using development strategies, negotiation and/or mediation or referral to Hurst Place (Employee Assistance Program). The manager is responsible for ongoing communication with all parties involved regarding the resolution process.

Stage 5 – Progressive Discipline
Before taking any steps towards progressive discipline, it is the responsibility of the manager to consult with Human Resources, unions and/or the Chief of Professional Practice or Practice Leader regarding staff and the Vice President Medical regarding physicians.

5.0 Documentation

Occurrence reporting (as per protocol)
Patient's health record

6.0 Definitions

Fragrance: aromas, scents or perfumes/colognes, aftershave or other scented products - anything that adds a smell to something else.

7.0 Cross References

Values Based Code of Conduct (VBCC)
Harassment Protocol
Occurrence Reporting Policy

8.0 External References

www.lung.ca
Niagara Health System Scent Free Policy
CAMH Scent Free Environment Guidelines
St. Mary's General Hospital Scent Reduced Environment Policy
Kingston General Hospital Scent-free Environment Policy
Whitehorse General Hospital Fragrance-Free Policy

9.0 Developed By

Risk Management
Occupational Health and Safety
Volunteer Association
Professional Advisory Committee
Office of the Vice President of Corporate and Medical
Office of Human Rights
Public Relations
Volunteer Resources

10.0 In Consultation

PAC
Volunteer Association
Volunteer Resources
Clinical Practice and Education
Human Resources
Joint Health and Safety
Human Rights
Patient Relations/Risk Management

11.0 Approved By

PAC
MAC
Joint Health and Safety
Operations

12.0 Appendices

Signage – Fragrance Restricted Environment
Fragrance Fact Sheet

Internet Protocol

HAMILTON HEALTH SCIENCES	ADMINISTRATION MANUAL
Posting Date:2007-04-26 **Posting History Dates***:*2001 09 02,2003 11 03, 2004-02-23, 2007-04-26	Page 1 of 4
Title: **I.C.T. – Internet Protocol**	

Applies to: Any individual accessing the Internet through Hamilton Health Sciences resources.

1.0 Purpose & Goals Description

This policy sets out the principles and acceptable standards for all individuals accessing the Internet services provided through the Hamilton Health Sciences. All information on the internet as accessed through Hamilton Health Science resources is the property of Hamilton Health Sciences, and that there is no implied or guaranteed right to privacy or ownership.

2.0 Policy

Employee's access to the Internet through Hamilton Health Sciences resources and equipment is provided to facilitate business use only. Hamilton Health Sciences retains the right to monitor and review the employee's Internet activity including opening email messages. Employee's may not solicit personal business, political or religious causes over the Hamilton Health Sciences network. Employee's must comply with all copyright, patent and trademark issues when using the Internet.

3.0 Etiquette

3.1 Hamilton Health Sciences encourages the use of Internet facilities to accomplish job responsibilities and further the Hospital mission, or related career development.

3.1.1 Hamilton Health Sciences staff have an obligation to learn about Internet etiquette, customs and courtesies, to be aware of computer security, and privacy concerns and to guard against viruses.

3.1.2 Examples of job-related use of the Internet include:

- accessing external databases to obtain reference information or conduct research;
- transferring draft documents for comments;
- disseminating Hospital news;
- accessing the text of manuals and self-teaching workbooks;
- connecting to resources that provide information related to educational opportunities;
- communicating with fellow members of a professional organization, etc.

3.2 Inappropriate Use

3.2.1 The use of Hamilton Health Sciences Internet facilities is a privilege and not a right. Employees are expected to use good judgment in their use of the Internet. Using the Internet is the main source of viruses found on the network.

3.2.2 Inappropriate use of the Internet results in penalties that range from having the privilege revoked to formal disciplinary action up to and including termination of employment.

3.2.3 Examples of unacceptable behavior, conduct and access are as follows:

- use of e-mail for unlawful or malicious activities;
- transmission or downloading (including printing) of any material that violates either the spirit or the intent of Ontario or Canadian law or Hamilton Health Sciences policies. This includes, but is not limited to copyrighted material, threatening or obscene material, or trade secret material.
- use of abusive or objectionable language;
- misrepresentation of oneself, or Hamilton Health Sciences, or exhibiting behaviour contrary to the Hospitals mission, vision and goals.
- revealing your user ID/password to any other person or staff member, allowing any other individual to sign on using your user ID/password
- use of strategies to bypass internal security guidelines;
- use of e-mail for personal gain, personal or private business;
- creation, sending, receipt, reply forwarding of chain letters, or personal mass mailings, materials which are sexist, racist, homophobic, sexually offensive or otherwise contrary to the Ontario Human Rights Code or the Canadian Human Rights Act, HHS property, including photographs and use of the HHS name and logo, without the express, written permission of HHS.
- distribution of pornographic material, violence, extreme political views, sexually suggestive jokes or the use of links or shortcuts to accomplish the same
- the conduct of Union business unless otherwise permitted through a separate agreement with a specific union
- any activity that may interfere with a staff member's work activities.
- usage of any non hospital mail system – i.e. hotmail, instant messenger
- staff "never" submit their name and email address to prompts, surveys, or contests on the Internet
- staff do not download any software (freeware or purchased) without the prior review/approval of I.C.T.
- staff do not load or use Real Audio types of software (music, games, radio) as this places heavy demands on the network bandwidth and can severely impact the hospitals production systems for communications
- screen savers are not downloaded from the Internet; this can cause unnecessary network traffic and may result in hospital applications not functioning properly, resulting in PCs not functioning properly and the need for unnecessary support calls.
- Staff do not access chat rooms or blogs from HHS networks

3.3 Director Manager Responsibilities

3.3.1 It is understood that all Directors and Managers reinforce these guidelines in their areas, and ensure that no misuse of the internet takes place in the hospital.

3.4 ICT Rights

3.4.1 I.C.T. reserves the right to delete inappropriate websites or screen savers from any hospital computer (including and not limited to include laptops, Blackberries or other such devices). In some cases re-imaging the computer is necessary. I.C.T. is not responsible for any lost data (corporate or personal) on any system that was re-imaged as a result of the above condition. I.C.T. also reserves the right to remove any or all data downloaded from the Internet (to conserve storage and reduce the backup resources).

3.5 Access Groups

Physicians, related companies, suppliers, temporary employees and contractors may be given access to the Hamilton Health Sciences Internet system, as business requires, and must abide by all Hamilton Health Sciences policies and procedure.

3.6 Service Provider

All Internet access must be through the Hamilton Health Sciences IS/T service provider. Direct Internet access through desktop modems is not permitted.

4.0 Procedure

4.1 Anti Virus Scrutiny

All inbound and outbound data is automatically subject to anti virus scrutiny. No executable files or programs or compressed files, or files containing hidden code (this includes JAVA, utilities, demos, etc.) are allowed to be transmitted into Hamilton Health Sciences without I.C.T management approval. I.C.T. reserves the right to perform periodic audits on computers to monitor the operation of this system, to access all documents downloaded from the Internet, and to retain/dispose of the information as it deems necessary without advance notice. The Director, Human Resources reviews and approve, if deemed appropriate, any request for access to a user's computer files.

5.0 Definitions

I.C.T - Information and Communication Technologies:

6.0 Cross References

Harassment Policy
HR Confidentiality
Employee Attitudes and Conduct
Progressive Discipline

7.0 Developed By

Senior Analyst Projects Team

8.0 In Consultation With

Information and Communication Technologies Manager Coordinator Team

9.0 Approved By

Director Information and Communication Technologies.

Keyword Assignment	

Nursing Student Practice Policy

HAMILTON HEALTH SCIENCES	*Clinical Patient Care Manual*
Posting Date: 2010-08-19 POSTING HISTORY DATE: 2004-06-18; 2007-08-07	*Page 1 of 6*
Title: **NUR - Nursing Student Practice Policy**	

Applies to: Student Education Coordinators, Registered Nurses, Registered Practical Nurses, Preceptors, Clinical Managers, Schools/Faculties, Education & Development Clinicians and Student Nurses

1.0 Purpose

1.1 **To identify the policy for placement and supervision of nursing students at Hamilton Health Sciences (HHS).**

1.2 To assist nursing students to fulfill the practical component of their course curriculum.

1.3 To promote HHS as an employer of choice for potential graduates of nursing programs.

2.0 Policy Statements

2.1 Responsibilities

2.1.1 **HHS Manager, Clinical Practice & Education for the Office of Student Education is responsible to:**

i. Place students at HHS through the negotiation of placements between the schools and the organization. The hospital's standard affiliation agreement is to be used when placements are negotiated from colleges or universities other than Mohawk College or McMaster University.
ii. Develop policies, procedures and related tools for student placements and education, in collaboration with the appropriate stakeholders.
iii. Act as a liaison between the schools and Education & Development Clinicians for negotiation of placements, assistance with problem solving and conflict resolution.
iv. Communicate trends of written student placement evaluation forms with relevant clinical programs.
v. Communicate changes in practice and related policies to colleges, universities and Education & Development Clinicians.
vi. Demonstrate healthy interpersonal communication in interactions with students and faculty.

2.1.2 **Education & Development Clinician is responsible to:**

i. Identify the nurses who are appropriate practitioners to function in the preceptor role, in collaboration with the Clinical Manager.
ii. Identify nursing skills that may be performed, in collaboration with the Clinical Manager.
iii. Collaborate with the Clinical Manager to determine the number of student opportunities available on the unit.
iv. Complete schedules for pre-grad and level IV students, according to a preceptor schedule and forward it to the school.
v. Act as a resource and support to staff in a preceptor role.
vi. Act as a liaison between preceptor and faculty as needed, to foster continuous improvement.
vii. Assist with problem-solving and conflict resolution as needed.

viii. Demonstrate healthy interpersonal communication in interactions with students and faculty.
ix. Act as a key contact and resource to faculty. Meet with faculty as necessary, discuss standards of care, learning resources and suggest learning opportunities.
x. Provide a clinical placement evaluation form to the Preceptor and Pre-grad or Level IV Student and encourage completion.
xi. Evaluate student placements, in collaboration with the Clinical Manager.
xii. Promote a supportive learning environment for students.

2.1.3 **General Responsibilities of All Registered Nurses and Registered Practical Nurses at HHS**

i. To promote a supportive learning environment for students.
ii. To be available to discuss a student's learning plan with the student and/or faculty in order to facilitate the student's learning.
iii. To have an awareness of the level of preparation of the student, the objectives of the experience and the specific assignment(s) of the student.
iv. To demonstrate healthy interpersonal communication in interactions with students and faculty.
v. To coordinate the care assigned or delegated to students and ensure it is safely completed.
vi. To inform the Clinical Manager, Education & Development Clinician and faculty of any issues related to patient safety.
vii. To respect the patient's right to refuse student care.
viii. To promote a supportive learning environment for students.

2.1.4 **Specific Responsibilities Of Registered Nurses and Registered Practical Nurses Whose Patients Are Receiving Partial Or Total Care From a Student**

i. To participate in the teaching/learning process.
ii. To understand the objectives of the student's experience.
iii. To understand the limits of the student's responsibilities and competence.
iv. To clearly communicate the specific assignment(s) to the student.
v. To assist the student with assigned activities and additional learning opportunities as they arise, as appropriate.
vi. To provide ongoing feedback to the student and the faculty.
vii. To place the safety and well being of the patient first in planning the learning experience with the student.

2.1.5 Responsibilities Of Registered Nurses and Registered Practical Nurses Who are Preceptors for Mohawk Practical Nursing Pregrad; Varied Context Level III, Level IV Post Diploma McMaster and Mohawk Students; and other Placement Students

i. To provide necessary supervision as mutually agreed with the student.
ii. To provide ongoing constructive and timely feedback (oral and/or written) to the student and faculty regarding the student's progress towards the objectives of the experience.
iii. To assess learning needs and recommend or facilitate possible learning experiences which meet the student's goals.
iv. To place the safety and well being of the patient first in planning the

learning experiences with the student.

v. To participate in student evaluation.
vi. To manage conflict in a timely and respectful manner.
vii. To problem solve and critically think through situations as they arise.
viii. To notify faculty if there are issues or concerns with student performance.
ix. To attend preceptor workshop to prepare for the preceptor role**.**

2.1.6 **General Responsibilities of the Clinical Manager**

i. To identify nurses who are appropriate practitioners to function in the preceptor role, in collaboration with the Education & Development Clinician.
ii. To identify nursing skills that may be performed in the clinical area, in collaboration with the Education & Development Clinician.
iii. To assess the workload of the nurses who are preceptors and the nurses whose patients are partially being cared for by students and make adjustments as necessary to ensure that nurses are available to communicate with and support the students.
iv. To evaluate student placements, in collaboration with the Education & Development Clinician.
v. To demonstrate healthy interpersonal communication in interactions with students and faculty.
vi. To facilitate attendance of selected staff nurses at preceptor workshops in preparation for precepting students.
vii. To promote a supportive learning environment for students.

2.1.7 **General Responsibilities of All Faculty**

i. To teach and supervise students.
ii. To provide an orientation to the clinical area, as appropriate.
iii. To provide the following information to the appropriate Education & Development Clinician. A listing of Education & Development Clinicians and responsible areas is available through the student placement coordinator's office at the college or university and HHS:
    - name of the students;
    - level of students;
    - name of the faculty and contact number;
    - hours that the student is on the unit;
    - limitations in the provision of care by the student(s);
    - amount of supervision provided.
iv. To ensure the appropriate hospital staff is aware of the objectives of the experience.
v. To clearly communicate the scope and limits of the student's responsibilities to the nurses involved.
vi. To place the safety and well being of the patient first in planning the learning experiences with the student.
vii. To practice nursing in accordance with the policies and procedures of HHS.
viii. To forward any concerns related to client safety to the Education & Development Clinician, Clinical Manager or Program Director.
ix. To provide feedback to the program regarding placements and evaluation of placements.
x. To complete written evaluations for students.

xi. To demonstrate healthy interpersonal communication in interactions with students and staff.
xii. To provide the clinical area with a business telephone number.

2.1.8 **Responsibilities of Students**

i. To prepare learning objectives for the experience and discuss with the preceptor and staff nurses working with the student.
ii. To identify/communicate personal competency in a skill/procedure.
Identification of competency includes:
- appropriateness of the procedure/skill to the student's level of learning;
- whether or not an activity or skill has been covered in the course of study at the college or university (HHS does not provide education for skills which are not covered in the course of study at the college or university level);
- whether the skill is new or has been performed previously and how often;
- how confident they feel;
- the plan of action for carrying out the activity/skill.

iii. To understand his or her role in the provision of care.
iv. To hold himself/herself accountable to the faculty for the quality of care delivery that is within the established objectives.
v. To notify the unit/area in advance if unable to attend a clinical experience and negotiate additional time as necessary.
vi. To provide feedback to the preceptor.
vii. To negotiate a learning plan with preceptor and/or tutor.
viii. To demonstrate healthy interpersonal communication skills with patients, families, staff and faculty.
ix. To respect the patient's right to refuse student care.
x. To complete written preceptor evaluation/feedback form and discuss with the preceptor.
xi. To complete written clinical placement evaluation form and forward to the Office of Student Education at HHS.

2.1.9 **Students may:**

i. Accompany a patient being transported to another agency provided they are accompanied by another nurse.
ii. Arrange an observational experience in another unit in consultation with their preceptor, faculty and the Clinical Manager and/or Education & Development Clinician in the desired area.
iii. Perform controlled act procedures authorized to nursing when under the supervision or direction of a Registered Nurse.
iv. Participate in the administration and management of controlled substances in the following ways:
- assess pain and a patient's need for pain medication under the supervision or direction of a Registered Nurse;
- after initial supervision by faculty or preceptor to verify competence, the student may subsequently, sign for and administer these substances independently (**Exception** – epidural administration);

- document the wastage of a controlled substance with the co-signature of a Registered Nurse or Registered Practical Nurse (as per the policy requiring two signatures);

2.1.10 **Students Are Not to be:**

v. Considered as staff members in any clinical areas.
vi. Allowed to accept verbal or telephone orders.
i. Allowed to assume charge or the functions of charge nurses in any area.
ii. Able to witness written consents.
iii. Assigning care to Health Care Aides.
iv. Permitted to participate in the administration and management of controlled substances in the following ways:
  - carrying the narcotic keys;
  - documenting wastage of a controlled substance with the co-signature of another student;
  - counting controlled substances for the shift;
  - transporting controlled substances to and from pharmacy

v. Permitted to check with the Regulated Health Professional that is skilled in the administration of blood and/or blood products, that the patient, transfusion medicine issue form and the blood and/or blood product are correctly identified as to:
  - patient's first and last name;
  - unique hospital ID number or temporary ID number (used in computer downtime);
  - written consent;
  - donor unit number (bag or bottle number);
  - typenex number, if utilized;
  - ABO-H group of the patient and blood product;
  - CMV status and irradiation (if applicable)
  - The student cannot provide the second check.

vi. Verifying and/or co-signing physician orders. The complete order set transcribed by the student must be verified and co-signed by a RN or RPN on the order sheet in the designated space and on the medication profile prior to the administration of any medications included in that set.
vii. Administering any epidural medication by syringe or infusion pump. Epidural pain management is not a basic nursing skill set covered in the four year basic nursing program.

Programming epidural pumps. In collaboration with their preceptor, students may provide components of care such as monitoring vital signs, motor and sensory scale assessments.

2.1.11 **WHMIS and Fire Education**

- Nursing students are required to complete general WHMIS and fire education. Students from McMaster University and Mohawk College receive general WHMIS and fire education from their school.
- Nursing students are to complete unit specific education for WHMIS and fire safety. Level III varied context, pregrad and level IV and post diploma students are to consult with their preceptor for this education. Other nursing students are to consult with faculty.

3.0 Definitions

Student - person placed at HHS for the purpose of gaining or advancing their discipline specific knowledge, skills or perspectives, enrolled in an academic course of study.

Preceptor - person who facilitates the learning opportunities or experiences for specific students.

Faculty - person supervising students in a clinical area who is employed by a college or university or holds a clinical appointment with a college or university.

Graduate Student - person in a graduate health professional program e.g. master's program.

4.0 Cross References

- The affiliation agreement between McMaster University, Mohawk College of Applied Arts and Technology and Hamilton Health Sciences sets forth the conditions governing student placements, learning experiences and the responsibilities of each involved.
- Blood and Blood Product Administration
- Transcription Process for Orders, General and Henderson Sites Only
- Transcription Process for Physician Orders, Chedoke and MUMC
- Transcription and Checking of Doctor's Orders, St. Peter's
- Epidural Pain Management Protocol – Adult Medical/Surgical
- Learning Package: Care for Women Receiving Epidural Analgesia during Labour and Delivery

5.0 External References

College of Nurses of Ontario. (2005). Supporting Learners.

6.0 Developed By/In Consultation With

Managers, Clinical Practice & Education (Clinical Education and Office of Student Education)
Vice President Professional Affairs and Chief Nursing Executive
Director, Clinical Practice & Education
Chiefs of Nursing Practice
Clinical Program Directors
Clinical Managers
Education & Development Clinicians
Faculty, Mohawk College and McMaster University

7.0 Approved By

Director Clinical Practice and Education
Vice President Professional Affairs and Chief Nursing Executive
Minor Revision by: Manager, Clinical Practice and Education

Personal Appearance Policy

HAMILTON HEALTH SCIENCES	HUMAN RESOURCES
Posting Date: 2010-12-31 *POSTING HISTORY DATES:* 1999-09-15	PAGE 1 OF 4
Title: **Personal Appearance**	

Human Resources applies knowledge and practices that support the organization's mission, vision, values, beliefs and behaviour. The policies outlined in this subsection set out the expectations of our employees, the behaviours we seek and those we do not tolerate.

1.0 Purpose & Goals Description

It is the intent of this policy to outline the appropriate clothing that protects Hamilton Health Sciences (HHS) patients, their families, staff and the community from work hazards. In addition, it is the desire of HHS to reflect an image that inspires the confidence of our clients and stakeholders.

2.0 Equipment/Supplies

None

3.0 Policy

3.1 Appropriate clothing serves as a protection from work hazards. At the same time, the personal grooming and appearance of staff reflect the professional image of HHS. The personal appearance of staff is an important component of Patient-Focused Care since staff are those whom patients, their families, visitors and the community see when they arrive at the hospital. First impressions make a lasting impression and as representatives of HHSC our staff's appearance may affect clients' perceptions of the hospital.

3.2 Clinical areas and non-clinical areas have differing personal attire needs due to the requirements of their work and the clients they serve. Therefore, appropriate personal attire in a non-clinical area may be inappropriate for a clinical area. Staff are to direct any questions regarding the appropriateness of their personal attire to their manager or director.

3.3 Garments/Protective Clothing Supplied by HHS: Any garments and protective clothing supplied by the hospital are for the exclusive use of the employee concerned and are to be worn during working hours only.

All garments supplied by HHS remain in the property of HHSC and must be returned on request or at termination of employment. Preserving and safeguarding hospital property is the responsibility of each employee. **Any garments, including scrubs/greens, that are purchased with hospital funds are the property of HHS and must be protected from theft, misuse and/or damage.**

Protective Clothing - (e.g. isolation gowns) serve the purpose of reducing the possibility of transfer of infectious organisms between patients. These gowns are for one use wear, confined to use in caring for isolation patients and are <u>not</u> to be worn as warm-up jackets.

3.4 It is recognized that given the diversity and services provided by individual programs and areas, each program and/or area may tailor a personal appearance policy for their specific area or use this corporate policy as their program/area policy. For those programs/areas wishing to develop their own policy, criteria to be considered in developing a policy has been included as an addendum to this policy.

3.5 General Statements on Personal Appearance

3.5.1 The following statements are based on safety, infection control and the image HHS wishes to reflect. Program/area leadership may tailor a personal appearance policy for their specific area using the appropriate statements.

STAFF SHOULD DIRECT ANY QUESTIONS REGARDING THE APPROPRIATENESS OF THEIR PERSONAL ATTIRE TO THEIR MANAGER OR DIRECTOR.

- shoes are to be worn at all times. Open toe and open back shoes (slip-ons) are generally not considered safe, except as determined by the program manager or director. In some cases, more protection may be required. Staff are to ask their manager or director for clarification.
- artificial nails for any staff involved with food services or direct patient care (includes but not limited to nursing units, clinics, operating rooms) are NOT permitted. Artificial nails for staff who are not involved in direct or indirect patient care are permissible but not encouraged due to the inherent risk of contamination.
- all employees must be clean and groomed.
- personal attire must be non-transparent and cover all private areas of the body.
- personal attire should be clean and neat. Clothing that is frayed, worn, torn or cut-off is not acceptable.
- dangling jewelry and loose clothing may be a safety hazard in some areas and are discouraged.
- clothing designated for patients is not to be worn by HHSC staff or others that are not patients of the HHSC.
- denim jeans or skirts are not considered acceptable attire during regular working hours. The following exceptions apply:
- at the discretion of the Program/Area Director, employees may wear jeans as necessary depending on the demands of their area (e.g. Program is moving to another location, moving of files, etc.)
- when the hospital identifies a specific day as a "Jeans Day" to encourage participation or awareness for an event or a cause (e.g. Mother's Day Telethon, United Way, etc). The Public Affairs department would communication the event to staff in advance.
- as outlined in 3.6 at the discretion of the Program/Area Director.

3.6 **Casual Days:** Depending on their role, employee may be encouraged to wear a more "relaxed" attire on Fridays. Senior Management identifies and communicates other periods when staff may be encouraged to wear casual attire. Neat and clean denim jeans or skirts are acceptable on these days at the discretion of the Program/Area Director, as long as they are not frayed, worn, torn or cut off. **Please note that on hospital-wide casual days managers may determine that normal dress is required for their staff due to the work demands in their Program/Area.**

3.7 **Summer Dress:** Depending on the employee's specific work assignments and the Program's requirements, Program or Area Directors may determine that it is appropriate for their staff to wear shorts during the summer months.

3.8 **References**
Please refer to the attached list of criteria for program/area leadership to consider when developing a program/area specific policy.

4.0 **Definitions**
None

5.0 **Cross References**
Employee Identification Policy.
Collective Agreements - Articles pertaining to Uniforms

6.0 **External References**
None

7.0 **Developed By/In Consultation With**
Chief Human Resources Officer
Human Resources Specialist, Employee Relations
Human Resources Specialist, Corporate Services
Uniforms/Scrubs Committee
Relevant Employee Groups

8.0 **Approved By**
CEO and President 1999-08-23
Chief Human Resource Officer 1999-08-17

Minor Revisions 2010 Approved by: Manager HR and Organizational Development

Keyword Assignment

CRITERIA TO CONSIDER IN DEVELOPING A PROGRAM/ AREA-SPECIFIC POLICY

1. If the policy encompasses any bargaining unit employees, the policy must not be inconsistent with a Collective Agreement.

2. The policy must not be unreasonable.

3. The policy must be clear and unequivocal.

4. The policy must be brought to the attention of the employee(s) before acted upon.

5. Employee(s) must be notified of any consequence of not complying with the policy.

6. The policy must be consistently enforced.

Managers / Directors should contact their HR Consultant if they require assistance in developing a program/area specific policy.

Use of Personal or Hospital supplied Mobile Electronic Devices at Work – Etiquette Policy

Hamilton Health Sciences	Page 59 of 103
Posting Date: 2016-02-08 **Posting History Dates*:*** **Next Review Date:** 2019-02-08	
Title: CORP - Use of Personal or Hospital supplied Mobile Electronic Devices at Work – Etiquette Policy	

Applies to: All HHS Staff, Hospital Affiliates, Members of the Medical, Dental, Midwifery Staff, Volunteers, Learners, Vendors, and Contractors.

1.0 Purpose

As technology advances, the use of Personal Mobile Electronic Devices (PMED) has grown and become a useful tool in some work environments. The purpose of this policy is to support professional and responsible behaviours that are expected while **performing your duties and/or while in public areas** of the Hospital related to the use of PMED. The use of personal mobile electronic devices should support effective communication, patient care delivery, the perception of patient care delivery, and enhance the overall patient experience.

Note: This document outlines the minimum expectations related to this subject. Programs may have department specific policies that exceed the expectations outlined in this document.

Note: Staff working in other facilities/locations, must adhere to this policy in addition to the specific facility policy where they are performing their duties.

2.0 Policy

2.1 Guiding Principles and Values

2.1.1 Patients, family members, and other team members deserve our full focus and attention when interacting with them.

2.1.2 Personal mobile electronic devices are to be used in a manner that does not interfere with or negatively impact patient care, the perception of patient care, the patient experience, and the responsibilities and duties of your position.

2.1.3 Maintaining confidentiality of personal health information (PHI), HHS business, and employee information is paramount whenever using personal mobile electronic devices.

2.1.4 Use of personal mobile electronic devices for **personal reasons while providing direct patient care and/or interacting with patients is not permitted.**

2.2 Safety

2.2.1 All users of PMEDs, are requested to be a distance of at least one meter from any medical device when in the hospital. Patients connected to medical instruments who are not in direct patient areas (in the cafeteria, elevators, hallways, etc.) are still at risk for electromagnetic interference (EMI) from radio frequency (RF) transmitting devices. An example is when a person using the device is near a patient who is mobile and has an infusion pump or other visible electronic apparatus. See BIOMED - Policy on the Safe Use of Cell Phones and Wireless Devices at HHS.

2.2.2 Any PMED that is charged within an HHS facility must use a CSA approved charger and only plugged into non-emergency power receptacles.

2.2.3 All users of PMED must follow HHS Infection Prevention & Control Routine Practices, which includes hand hygiene. See IC - Routine Practices Policy #: 041-MED

2.2.4 Persons using PMED are accountable for cleaning their devices following infection prevention and control policies.

2.2.5 The use of ear buds and/or headphones while performing your duties is prohibited, unless the use of the above is required for the primary function of your role, a safety device, and/or personal assistive device.

2.2.6 It is the responsibility of all persons to whom this policy applies, to ensure that you use mobile electronic devices safely. Staff are not to use mobile electronic devices while driving or operating powered or moving machinery.

2.3 Respect for Others

2.3.1 When using PMED while at work, devices must be placed on 'vibrate', 'silent', or 'alerts off' modes to minimize the level of noise and distractions in our environments.
When using PMED while at work, use of speaker phone capabilities should be minimized whenever possible. If speaker phone capabilities are used, you must comply with HHS Privacy and Confidentiality policies. See HR – Confidentiality Policy, HR – Employee Records & Confidentiality of Employee Information Policy, PRI – Privacy Policy

2.3.2 When using PMED in front of patients, families, and/or colleagues, it is expected that you will provide an explanation about your use of the device.

2.3.3 **Follow these three steps:**
a) Notify patient/family/colleague that you are going to access your PMED
b) Explain what you are accessing.
c) If appropriate, share the information.

2.3.4 When communicating using PMEDs, you must not violate HHS' commitment to harassment free and violence free working environment.
See CORP - Values Based Code of Conduct and HSW – Violence in the Workplace Policy.

2.4 Privacy & Confidentiality

2.4.1 All individuals using PMEDs while at work must comply with Personal Health Information Protection Act (PHIPA), the Freedom of Information and Protection of Privacy Act (FIPPA) and HHS Policies, specifically related to appropriate storage and safeguarding of confidential business, employee, and/or personal health information (PHI).
PRI – Privacy Policy, HR – Confidentiality Policy, HR – Employee Records & Confidentiality of Employee Information Policy

2.4.2 Individuals using PMEDs at work must employ safe practices when sending personal health information by sending only to 'secure' email recipients as per guidelines in the Electronic Mail Policy. See ICT – Electronic Mail (email) Protocol

2.4.3 Texting of personal health information is not permissible.

2.4.4 Individuals using PMEDs at work will not discuss or view confidential information near those who should not have access to the information in compliance with their confidentiality obligations as per the Privacy Policy.

2.4.5 Texting of employee information for the purposes of scheduling may be used if the employee has provided informed consent.

2.4.6 Regulated Health Professionals will also comply with their respective Regulatory College Standards of Practice regarding professional behaviours, use of social media, and any other applicable standards that may relate to PMED at work.

2.5 Accountability

2.5.1 All persons for whom this policy applies are accountable for meeting the minimum expectations outlined herein.

2.5.2 All persons for whom this policy applies are accountable to ensure that the use of PMEDs at work does not negatively impact the therapeutic relationship with patients and families.

2.5.3 Upholding the professional and responsible behaviours expected of all persons related to mobile electronic devices is everyone's responsibility. When team members address compliance issues, you must apply the HHS Values Based Code of Conduct.

2.5.4 If accessing Information and Communication Technologies (ICT) resources on your PMED, you must follow ICT policies, including Bring Your Own Device (BYOD) and Wireless Network policies. See ICT – Bring Your Own Device (BYOD).

2.5.5 Leaders are accountable for enforcing this policy.

3.0 Definitions

Confidential Information **- As an employee of HHS, all clinical or health related, personal, Human Resource, social and / or psychological information concerning patients, visitors and staff is held in strictest confidence; regardless of whether access to such information was verbal, documented, computerized or otherwise obtained. Employees divulge, obtain and/or use confidential information only as needed by them to perform legitimate duties of their job. Inappropriate access, disclosure, misuse or failure to safeguard confidential information is subject to severe disciplinary action up to and including termination.**

Electro-magnetic Interference (EMI) - R.F. transmitting devices generate electro-magnetic interference (EMI) that may affect the normal use of other electronic equipment including medical devices used for diagnostic and therapeutic purposes. Such interference can cause devices to malfunction, under-perform or provide erroneous data, which may lead to substandard care, injury or even death. The risk of radio-frequency interference is a function of power, proximity of the transmitter, and susceptibility of certain pieces of equipment.

High-risk areas - Any area where a patient might be connected to electro-medical equipment (e.g. cardiac monitoring, hemodynamic monitoring and telemetry) and any highly instrumented area (e.g. clinical laboratories). This includes but is not limited to Emergency, ICU, CCU, PACU, ORs, L&D, NICU, Diagnostic Imaging,

Medical Diagnostic Units, and Clinical Laboratories.

Medical Device (as defined in the Health Canada Food and Drugs Act) - Covers a wide range of health or medical instruments used in the treatment, mitigation, diagnosis or prevention of a disease or abnormal physical condition. Examples include ventilators, monitors, infusion pumps, etc.

Personal Health Information (PHI) – Personal Health Information is defined in PHIPA s.4 as identifying information about an individual in either oral or recorded form that relates to the physical or mental health of the individual; relates to the provision of healthcare to the individual, including the identification of a provider of healthcare to the individual.

Personal Mobile Electronic Devices (PMED) - Are portable electronic devices that are used for communication and accessing information. This includes but is not limited to the following: cell phones, laptops, tablets, SMART phones/watches, Personal Digital Assistants (PDA). This applies to both personal devices and those supplied by HHS.

Radiofrequency (RF) [abbreviated RF, rf, or r.f.] - A term that refers to alternating current (AC) having characteristics such that, if the current is input to an antenna, an electromagnetic (EM) field is generated suitable for wireless broadcasting and/or communications. These frequencies cover a significant portion of the electromagnetic radiation spectrum, extending from nine kilohertz (9 kHz), the lowest allocated wireless communications frequency (it's within the range of human hearing), to thousands of gigahertz (GHz). The frequency of an RF signal is inversely proportional to the wavelength of the EM field to which it corresponds. At 9 kHz, the free-space wavelength is approximately 33 kilometers (km) or 21 miles (mi). At the highest radio frequencies, the EM wavelengths measure approximately one millimeter (1 mm). As the frequency is increased beyond that of the RF spectrum, EM energy takes the form of infrared (IR), visible, ultraviolet (UV), X rays, and gamma rays.

4.0 Cross References

BIOMED - Policy on the Safe Use of Cell Phones and Wireless Devices at HHS
CORP – Harassment Protocol
HR – Confidentiality Policy
HR – Employee Records & Confidentiality of Employee Information Policy
IC - Additional Precautions Protocol
IC - Routine Practices Policy #: 041-MED
ICT – Bring Your Own Device (BYOD)
ICT – Electronic Mail (email) Protocol
ICT – Encryption Policy
ICT - HHS Wireless (WiFi) Access Policy
ICT - Mobile Device Policy
PRI – Privacy Policy

Posting Date: 2016-02-08 **Posting History Dates*:*** **Next Review Date:** 2019-02-08
Title: CORP - Use of Personal or Hospital supplied Mobile Electronic Devices at Work – Etiquette Policy

5.0 Other HHS References

Admin HHS – Administrative & Professional Staff By-law 3
CORP - Values Based Code of Conduct
HSW – Violence in the Workplace Policy
PR&C - Social Media Policy
VOL – Volunteer Code of Ethics Policy

6.0 External References

Capital Health – Wireless Communications Devices Etiquette in the Patient Care Environment Policy – 2011

ECRI Institute. (2013). *Guidance Article: Getting the Message. Results of our Survey on Cell Phone/Smartphone Policies.* Retrieved from https://www.ecri.org/components/HDJournal/Pages/hd201304guid_SurveyCellPhones.aspx

Horizon Health Network – Appropriate Use of Wireless Communication Devices Policy – 2013

Royal Victoria Regional Health Care – Mobility – Bring Your Own Device (BYOD) Policy & Procedure - 2013

Waypoint Centre for Mental Health Care – Mobile Devices Policy - 2012

7.0 Developed By

Personal Mobile Electronic Device Working Group

8.0 In Consultation With

HHS Staff and Physicians
HHS Leaders
Office of Human Rights & Diversity
Privacy & Freedom of Information Office

9.0 Approved By

Joint Chief/Directors Forum – 2015
MAC – March 2015
Executive Council December 2015

Keyword Assignment	Devices, electronic devices, etiquette, cell phones, tablets, blackberries, smart phones, mobile, personal, PMED, PMEDs, PMED's

END OF DOCUMENT

Personal Mobile Electronic Devices (PMED)

Can a PMED be used in a clinical area?	**YES**, but only for the purpose of patient care while in the clinical setting.
Can a PMED be used for personal use?	**YES**, but not while providing direct patient care or interacting with patients and families.
Can I use my PMED at the bedside?	PMEDs cannot be used within at least 1 meter of any medical device (on or off-the clinical unit).
Can I use earbuds/headphones in my PMED?	**NO**, unless it is a requirement of your job.
Do I need to clean my PMED?	**YES**, you must follow all infection control cleaning practices and hand hygiene practice.
Can my alerts and alarms be activated on my PMED?	**NO**, all alerts and alarms on your PMED must be set to vibrate or silent.
How will patients, families and co-workers be informed of why I am using my PMED?	It is expected that you inform patients, families and co-workers when and why you are using your PMED.
Can confidential information be passed on my PMED?	The Freedom of Information and Protection of Privacy Act must be followed – personal health information can only be sent through secure servers Refer to: • **ICT - Electronic Mail (E-mail) - Policy** • **ICT - Guidelines for Safeguarding Privacy** • **HR - Confidentiality** • **HR - Employee Records and Confidentiality of Employee Information**
Is texting of personal health information permitted?	**Never**
Is texting pertaining to schedules permitted?	Only if the employee provides informed consent
Do HHS ICT and Biomed policies apply to the use of a PMED?	**YES**
Who is responsible to insure compliance with the PMED and related policies?	Everyone at HHS

Safe Use of Cell Phones and Wireless Devices Policy

HAMILTON HEALTH SCIENCES	*Clinical Manual*
Posting Date: 2011-08-05 **POSTING HISTORY DATES:** 2006-02-01; 2009-02-03;2010-09-28 (REVIEWED)	*Page 1 of 11*
Title: **BIOMED - Policy on the Safe Use of Cell Phones and Wireless Devices at HHS**	

Applies to: All staff, visitors, patients, physicians, contractors, and vendors.

1.0 Purpose

To manage the electromagnetic (EM) environment including radiofrequency (RF) transmitter use, new equipment purchases and education of staff, patients, and visitors. It describes certain devices, where they can be used, and by whom.

2.0 Device Types

2.1 Cellular Phones and BlackBerries

2.1.1 Patient and visitor use of cellular phones and BlackBerries is prohibited in all areas of the hospital except: lobbies, cafeterias, public hallways, and business offices (e.g. Admitting, Cashier, Medical Records, non-clinical support offices etc). The devices must be turned off when entering clinical areas (wards, cardiac, critical care, outpatient rooms, diagnostic test areas such as Medical Diagnostic Unit, etc.)

2.1.2 All users of cellular phones or BlackBerries, are requested to be a distance of at least one meter from any medical device when in common areas of the hospital. Patients connected to medical instruments in the cafeteria, elevators, or hallways, are not in direct patient areas but are still at risk for electromagnetic interference (EMI) from RF transmitting devices. An example is when a person using the device is near a patient who is mobile and has an infusion pump or other visible electronic apparatus.

2.1.3 Staff are responsible to caution patients who are discharged with devices associated with continued treatment (e.g. enteral feeding pumps, ventilators, etc) not to use a cellular phone or BlackBerry while these devices are operating and that visitors and family with operating cellular phones or Blackberry to be a minimum distance of one meter from the device.

2.1.4 Staff in all patient care areas are allowed to use cellular phone and BlackBerries only for patient care applications and must maintain a minimum distance of 1 meter from any medical device otherwise they are to be turned off. Staff are asked to set their devices to vibrate mode whenever possible and to use discretion when discussing private and confidential matters. For areas other than patient care, a minimum distance of one meter is to be maintained from any medical device when using a cell phone.

2.2 Wireless Network Devices (Wi-Fi)

2.2.1 Staff may use Wireless Network Devices (Wi-Fi) throughout our facilities but must be a distance of at least one meter from any medical device when using or carrying the wireless device.

2.2.2 Patients and visitors are allowed to use Wireless Network Devices (WiFi) in all areas where public wireless networking is made available by the hospital via the SSID 'i-Visitor'. The devices may be required to be turned off when entering certain critical clinical care such as Diagnostic Services, CCU's, treatment rooms or

when requested by HHS staff member due to possible interference with critical patient care devices.)

2.3 Two-Way Radios

2.3.1 Patients and visitors are prohibited from using two-way radios (walkie-talkies, General Mobile Radio Service, Family Radio Services) in all indoor areas and entrance vicinities of the hospital.

2.3.2 Typical users like emergency personnel (e.g. EMS, Police, Fire, etc), Engineering Maintenance, and Security Services must refrain from keying (talking/transmitting) their two-way radios while in clinical areas and the Emergency Department. In all other areas, users must maintain a minimum distance of 3 meters (~10 feet) from medical devices when keying (talking).

2.4 All staff, patients and visitors are prohibited from using Cordless Phones in the hospital.

3.0 Procedure

3.1 Inadvertent or Improper use of RF Transmitting Devices

3.1.1 In the event that an RF transmitting device becomes activated within a high-risk area or that policy is not being followed, staff are requested to inform the user to immediately refrain from using the device or move to an unrestricted area.

3.1.2 If a person continues to use the device in a restricted area after being made aware, staff must notify the area charge person who will notify Security Services. Persons refusing to comply with this policy (whether they be hospital staff, physicians, visitors, etc.) may be removed from the premises.

3.1.3 If clarification is required to resolve a particular problem, contact the Manager of Biomedical Technology for recommendations.

3.1.4 Use of cellular phone technology (or any other device) to make photographic, video, or audio recordings/capture without consent, is strictly prohibited.

3.2 Signage/Labeling

3.2.1 Signs to manage the use of RF transmitting devices are posted at all entrances to high-risk areas. Signs indicating hospital policy are posted at all entrances to the hospital.

Facility Entrance

Cellular phones, BlackBerries, two-way radios, must remain OFF in all area of the hospital except lobbies, cafeterias, public hallways, and business offices.

Zone Entrance

Cellular phones, BlackBerries, two-way radios, must be turned OFF before entry.

Public Areas

Please keep cellular phones, BlackBerries, and other wireless devices at least one meter away from any medical device; authorized two-way radios must remain at least three meters away from any medical device when keyed.

3.2.2 Although the risk is low, certain medical devices have proven to be more susceptible to RF energy than other devices at distances of less than one meter. These include fetal monitors, ventilators, incubators, and infant radiant warmers. As an added precaution, these devices have a label attached indicating a 'one meter WIRELESS-FREE RADIUS.' This cautions against the use of wireless devices within a one meter radius of the labeled device.

3.3 Monitoring the Electromagnetic Environment

3.3.1 Any equipment problems or failures suspected as EMI problems are to be reported to Biomedical Technology immediately. Staff are to make note of date, time, any electronic equipment in the proximity, a complete description of the nature of the problem, and any other circumstances that may be noteworthy.

3.3.2 Problems that cannot be duplicated are to be investigated and trend analysis performed to determine if there is some correlation to EMI, ad hoc EMI testing might need to be performed.

3.3.3 Installation of any wireless systems or devices other than personal communication devices must be authorized by Information and Communication Technology (ICT) for wireless networking or RFID, Telecommunications and ICT for communication devices, and Biomedical Technology for all wireless applications including medical telemetry. Wireless devices found to be detrimental to existing equipment in the hospital will be prohibited.

3.4 Pre-purchase Evaluation for Electromagnetic Compatibility (EMC)

3.4.1 All medical devices must meet requirements pertaining to EMC. Pre-purchase evaluations of medical devices include criteria for compliance with relevant EMC standards.

3.4.2 Medical equipment manufacturers must provide evidence of the extent to which their devices conform to current electromagnetic susceptibility performance levels (e.g., guidelines, standards). An example of such evidence would be a certificate of compliance with any of the following standards: IEC601-1-2: 2004, EN60601-1-2, CAN/CSA – C22.2 No. 601.1.2 – 94 (R2004). *Note: Compliance with such standards does not guarantee that a device will be totally immune to EMI but represents a minimum immunity level.*

3.4.3 Purchase requisitions for all wireless devices must be reviewed by Biomedical Technology, ICT, and Telecommunications, to determine potential for interference.

3.5 Education of Staff, Patients, and Visitors on the Effects of EMI

3.5.1 All new staff receives information on the use of cellular phones and other wireless devices at HHS. Staff are responsible for being knowledgeable about the EMI risk of wireless devices and must ensure their safe and proper use.

3.5.2 Rules regarding the use of RF transmitting devices are communicated to patients at the time of admission. Instructions are included in the information package given to patient as well information on how to connect to the HHS Guest network 'i-Visitor'.

3.5.3 Signage throughout the facility serves to notify visitors of restrictions for RF transmitting devices. Visitors seen using these devices in unauthorized areas must be informed of the possibility of interference with medical equipment and that they are only allowed to use them in public areas of the facility.

3.5.4 All departments (Engineering and Capital Development especially) are responsible to communicate and enforce this policy pertaining to outside contractors and vendors.

4.0 Definitions

BlackBerry©: Copyrighted term referred to a hand-held device made by RIM (Research In Motion) and is marketed primarily for its wireless email, web, and mobile phone capabilities. Through commercial partners, BlackBerry also provides access to other Internet services. BlackBerry is also a personal digital assistant (PDA) that can include software for maintaining a built-in address book and personal schedule. In addition, it can also be configured for use as a Pager. Other similar devices are on the market such as the Palm Treo.

Bluetooth: is an industrial specification for wireless personal area networks (PANs). Bluetooth provides a way to connect and exchange information between devices like personal digital assistants (PDAs), mobile phones, laptops, PCs, printers and digital cameras via a secure, low-cost, globally available short range radio frequency.

Cellular Phone: Cellular telephone; cellular telephone service is a type of short-wave analog or digital telecommunication in which a subscriber has a wireless connection from a mobile telephone (cellular phone) to a relatively nearby transmitter. The transmitter's span of coverage is called a cell. Generally, cellular telephone service is available in urban areas and along major highways. As the cellular telephone user moves from one cell or area of coverage to another, the telephone is effectively passed on to the local cell transmitter. There are analog and digital technologies. Some mix both into the same phone. Digital phones use complex coding systems to reduce interference, noise, and security risk. Analog and digital phones share the same cell tower infrastructure while PCS devices use a separate digital-only tower system.

Cordless Telephone: A wireless handset, which communicates with a base station, connected to a fixed telephone landline via radio waves; can only be operated close to its base station, such as in and around the house. Unlike a standard telephone, a cordless telephone needs household mains electricity to power the base station. The cordless handset is powered by a battery which is recharged by the base station when the handset is connected to the base station when not in use.

Clinical Areas: all areas offering patient care and/or testing including critical care areas, patient care wards, outpatient services, medical diagnostics, and imaging (Xray, ultrasound, CT, MRI, Nuclear medicine).

Critical Care Areas: Equipment-intensive areas such as ICU, CCU, OR, HIU, PACU, ER, Step-Down units, Day Surgery, etc.

Electromagnetic Compatibility (EMC): EMC refers to the capability of electronic devices to function properly in the electromagnetic environment of intended use and to not emit levels of electromagnetic energy that cause EMI in other devices in the vicinity.[1]

Electro-magnetic Interference (EMI): R.F. transmitting devices generate electro-magnetic interference (EMI) that may affect the normal use of other electronic equipment including medical devices used for diagnostic and therapeutic purposes. Such interference can cause devices to malfunction, under-perform or provide erroneous data, which may lead to substandard care, injury or even death. The risk of radio-frequency interference is a function of power, proximity of the transmitter, and susceptibility of certain pieces of equipment.

Emergency Personnel: Police, Fire, Ambulance

Family Radio Services (FRS): The Family Radio Service is an improved walkie-talkie system. This personal radio service uses frequencies in the UHF band, and so does not suffer the interference effects found on Citizens Band (CB) at 27 MHz, or the 49 MHz band also used by cordless phones,toy walkie-talkies, and baby monitors. FRS uses FM instead of AM, and has a greater reliable range than license-free radios operating in the CB or 49 MHz bands.

Field Strength: The magnitude of an electric, magnetic, or electromagnetic field at a given point. The field strength of an electromagnetic wave is usually expressed as the rms [root mean square] value of the electric field, in volts per meter.[29]

General Mobile Radio Service (GMRS): GMRS radios are typically handheld portable devices much like Family Radio Service (FRS) radios, and share some frequencies. Mobile and base station-style radios are available as well, but these are normally commercial UHF radios often used in the public service and commercial land mobile bands. These are perfectly legal and their use is encouraged. They are more expensive than the walkie talkies typically found in discount electronics stores, but are higher quality.

High-risk areas: Any area where a patient might be connected to electro-medical equipment (e.g. cardiac monitoring, hemodynamic monitoring and telemetry) and any highly instrumented area (e.g. clinical laboratories). This includes but is not limited to Emergency, ICU, CCU, PACU, ORs, L&D, NICU, Diagnostic Imaging, Medical Diagnostic Units, and Clinical Laboratories.

Medical Device: (as defined in the Health Canada Food and Drugs Act) covers a wide range of health or medical instruments used in the treatment, mitigation, diagnosis or prevention of a disease or abnormal physical condition. Examples include ventilators, monitors, infusion pumps, etc.

Mission Critical: Description of an activity that must be carried out with little or no option. A high priority function that must be maintained regardless of other factors or would otherwise result in a major negative impact.

Patients and visitors: Includes all patients (in- and out-patients), visitors, and visiting physicians.

Personal Communication Services (PCS): also referred to as Personal Communications Networks (PCN), and PCS Systems. Term applied to the technology infrastructure in which current digital cellular phones use (1900 MHz range) versus the 800 MHz range used by original cellular providers. PCS was initially used to cover high concentrations of users in urban areas or large organizations. PCS phones are completely digital. They use a separate set of towers and set of frequencies -- between 1.85 and 1.99 gigahertz (GHz). Because of the higher frequencies, there must be more towers closer together. Because it is completely digital, encryption and error-correcting codes can make the call much clearer and nearly impossible to intercept.

Personal Digital Assistant (PDA): (e.g. Palm Pilot or Pocket PC); a hand-held device that stores and displays a built-in address book, personal schedule, documents, and email; can run applications designed for use on a PDA; can also be upgraded to a Wi-Fi transmitter (wireless PDA).

Radiofrequency (RF): (abbreviated RF, rf, or r.f.) is a term that refers to alternating current (AC) having characteristics such that, if the current is input to an antenna, an electromagnetic (EM) field is generated suitable for wireless broadcasting and/or communications. These frequencies cover a significant portion of the electromagnetic radiation spectrum, extending from nine kilohertz (9 kHz), the lowest allocated wireless communications frequency (it's within the range of human hearing), to thousands of gigahertz (GHz). The frequency of an RF signal is inversely proportional to the wavelength of the EM field to which it corresponds. At 9 kHz, the free-space wavelength is approximately 33 kilometers (km) or 21 miles (mi). At the highest radio frequencies, the EM wavelengths measure approximately one millimeter (1 mm). As the frequency is increased beyond that of the RF spectrum, EM energy takes the form of infrared (IR), visible, ultraviolet (UV), X rays, and gamma rays.

Radiofrequency Identification (RFID): is a technology that incorporates the use of electromagnetic or electrostatic coupling in the radio frequency (RF) portion of the electromagnetic spectrum to uniquely identify an object, animal, or person. RFID is coming into increasing use in industry as an alternative to the bar code. Low-frequency RFID systems (30 KHz to 500 KHz) have short transmission ranges (generally less than six feet). High-frequency RFID systems (850 MHz to 950 MHz and 2.4 GHz to 2.5 GHz) offer longer transmission ranges (more than 90 feet). In general, the higher the frequency, the more expensive the system.

Radiofrequency Transmitting Devices: Include but are not limited to: cellular telephones (cellular phones), cordless phones, two way radios (walkie-talkies), Citizen band (C.B.) radios, Ham radios and devices with R.F. modulators such as video games, Wi-Fi devices, wireless Internet-based communications devices (such as "BlackBerries"), RFID, and medical telemetry systems. Pagers are not subject to this policy because they do not transmit radio frequencies (they only receive). Cellular phones that convert to pagers fall within the restrictions of cell phones as they may still operate as transmitters on a regular basis to the local cell station for location and identification.

Staff: Physicians, volunteers, and all hospital employees including students.

Standby Mode: When on standby mode, cellular phones transmit automatically (every 5 to 10 minutes) to the local cell station for location and identification; therefore non-transmission can only be insured when the unit is turned off.

Two-way Radio: Hand-held radio transceivers; generally used by police, fire, ambulance, construction crews, etc. Makes use of Citizen's Band (CB) frequency range. These devices require the operator to key (push and hold 'talk' button) to transmit voice. FRS/GMRS devices are also considered two-way radios but operate at different frequency ranges.

Use: The verb 'use' in the context of R.F. transmitting devices indicates that a device is turned on (or keyed to transmit in the case of two-way radios) even if you are not talking or sending. Therefore cell phones, BlackBerries, and wireless network devices (Wi-Fi) must be turned off in restricted areas unless you are exempted staff for certain areas and applications.

Wireless Fidelity (WiFi): or known as wireless network systems or wireless LANs (local area networks) and associated devices; enabled by the implementation of transmit/receive antennas (access points) installed throughout an area or facility and operates similar to, and compatible with, an existing wired computer network. Mobile devices such as laptops, PDAs, digital tablets, IP phones, and even desktop PCs; can communicate with the wireless network, if retrofitted with a wireless interface card.

5.0 External References

1. Association for the Advancement of Medical Instrumentation. Guidance on Electromagnetic Compatibility of Medical Devices for Clinical/Biomedical Engineers. Arlington, VA: Association for the Advancement of Medical Instrumentation; 1997. AAMI TIR 18-1997. http://www.aami.org.
2. Grant H, Segal B, eds. Managing Wireless Electromagnetic Compatibility Issues in Healthcare: A Resource Manual. Center for the Study of Wireless EMC, Norman, OK: University of Oklahoma; 1998. http://www.ou.edu/engineering/emc/projects/news1.html.

3. Medical Devices Agency. Electromagnetic Compatibility of Medical Devices With Mobile Communications. London: Medical Devices Agency; 1997. Device bulletin. MDA DB 9702.
4. Segal B, Retfalvi S, Townsend D, Pavlasek T. Recommendations for electromagnetic compatibility in health care. Compliance Eng. 1996; 14:81-83. http://www.ce-mag.com.
5. ECRI. Guidance article. Cell phones and walkie-talkies: is it time to relax your restrictive policies? Health Devices. 1999;28:409-413. http://www.ecri.org.
6. Joint Commission on Accreditation of Healthcare Organizations. Managing Electromagnetic Interference. The Environment of Care Series. Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations; 1997. EC/PTSM-844. http://www.jcaho.org.
7. David Y, Paperman WD, Storch J. EMC How to Manage the Challenge. Healthcare Facilities Management Series. Chicago, IL: American Society for Healthcare Engineering of the American Hospital Association; 1997. No. 055144. http://www.ashe.org.
8. Medical Devices Agency. Emergency Service Radios and Mobile Data Terminals: Compatibility Problems With Medical Devices. London: Medical Devices Agency; 1999. Device bulletin. MDA DB1999(02).
9. Hamilton J. Electromagnetic interference can cause hospital devices to malfunction, McGill group warns. Can Med Assoc J. 1996; 154:373-375.
10. Silberberg JL. Performance degradation of electronic medical devices due to electromagnetic interference. Compliance Eng. 1993;10:25-29. http://www.ce-mag.com
11. Witters D. Medical devices and EMI: the FDA perspective. Available at: http://www.fda.gov/cdrh/emc/persp.html. Accessed November 1999.
12. Hayes DL, Wang PJ, Reynolds DW, et al. Interference with cardiac pacemakers by cellular telephones. N Engl J Med. 1997; 336:1473-1479.
13. Hayes DL, Carrillo RG, Findlay GK, Embrey M. State of the science: pacemaker and defibrillator interference from wireless communication devices. Pacing Clin Electrophysiol. 1996; 19:1419-1430.
14. Silberberg JL. What can/should we learn from reports of medical device electromagnetic interference? Compliance Eng. 1996;13:41-57. http://www.ce-mag.com .
15. Barbaro V, Bartolini P, Senassi M, Di Nallo AM, Reali L, Valsecchl S. Electromagnetic interference by GSM cellular phones and UHF radios with intensive-care and operating room ventilators. Biomed Instrum Technol. 2000;34: 361-369. http://www.aami.org.
16. Accredited Standard Committee on Electromagnetic Compatibility, American National Standards Institute. Recommended Practice for an On Site, Ad-Hoc Test Method for Estimating Radiated Electromagnetic Immunity of Medical Devices to Specific Radio-Frequency Transmitters. New York, NY- American National Standards Institute; 1996. ANSI C63.18. http://www.ansi.org. Can also be purchased at Global Engineering Documents at http://global.ihs.com.

17. Hatem MB. Managing the airwaves: new FCC rules for wireless medical telemetry. Biomed lnstrum Technol. 2000;34:177-181. http://www.aami.org .
18. Federal Communications Commission ruling establishing wireless medical telemetry service. Available at: http://www.fcc.gov/Bureaus/Engineering_Technology/News_Releases/2000/nret0009.html. Accessed December 2000.
19. Movshin LJ, Cooney TJ, Cohen JS. Comments of the American Hospital Association Task Force on Medical Telemetry. ET Docket No. 99-255. Hearing Before the Federal Communications Commission, Washington, D.C.; September 16, 1999. Available at: http://haifoss.fcc.gov/prod/ecfs/retrieve.cgi?native_or_pdf+pdf&id_document=6009450995.Accessed December 2000.
20. Turcotte J, Witters D. A practical technique for assessing electromagnetic interference in the clinical setting: ad hoc testing. Biomed Instrum Technol. 1998;32:241-252. http://www.aami.org.
21. Williams RD. Keeping medical devices safe from electromagnetic interference. FDA Consumer. 1995;29:113-116.
22. International Electrotechnical Commission. Medical Electrical Equipment; Part 1: General Requirements for Safety; Section 2: Collateral Standard: Electromagnetic Compatibility Requirements and Tests. Geneva, Switzerland: International Electrotechnical Commission; 1993. IEC 60601-1-2. http://www.iec.ch. Can also be purchased at Global Engineering Documents at http://global.ihs.com.
23. Lyznicki JM, Altman RD, Williams MA for the Council on Scientific Affairs. Report of the American Medical Association (AMA) Council on Scientific Affairs and AMA Recommendations to Medical Professional Staff on the Use of Wireless Radio-Frequency Equipment in Hospitals. Biomed Instrum Technol. 2001;35:189-195. http://www.aami.org .
24. Joint Commission on Accreditation of Healthcare Organizations. Environment of Care Essentials for Health Care. Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations; 2001. ECE-01. http://www.jcaho.org.
25. Elements of the Niagara Health System policy on the use of wireless devices in their facilities.
26. Elements of the Ottawa Civic Hospitals policy on the use of wireless devices in their facilities.
27. Mobile Basics – http://www.mobilein.com/mobile_basics.htm
28. Rogers Wireless Healthcare Symposium, London, Ontario, September 22, 2005 - Health Canada's Electromagnetic Compatibility Research: Electromagnetic Interference from Wireless Telecommunication Systems on Electromedical Devices - Implications for Setting Hospital Policies, Kok-Swang Tan (Ph.D, FIPH, M. Inst.P., MACCE, Health Canada – Medical Devices, Medical Devices Bureau, Therapeutic Products Directorate, Health Products and Food Branch, Health Canada -

http://www.unrealideas.com/rogershealthsymposium/Dr%20Tan.pdf

29. ATIS (Alliance for Telecommunications Industry Solutions) http://www.atis.org/tg2k/_field_strength.html
30. Ensil International Corporation, Wireless Communication Bands, http://www.ensil.com/Database/DB-Communication/DCom-Wireless%20Bands.html
31. Wikipedia On-line Encyclopedia, http://en.wikipedia.org/wiki/Main_Page
32. London Health Sciences Centre, London Ontario, Policy on' Use of Cell Phones and Other Wireless Technologies,' 2005.
33. Medical College of Wisconsin, HeathLink Website, http://healthlink.mcw.edu/article/950308896.html.
34. Information on cordless phones, http://electronics.howstuffworks.com/cordless-telephone4.htm.
35. Focus on Medical Telemetry, Medical Telemetry Frequency Bands: How Should Hospitals Approach their Decision On Which Band to Use? Steven D. Baker, PhD; Michael Larsen, BS; and J. S. Wiley, MS; Journal of Clinical Engineering, 2001 - http://www.monitoring.welchallyn.com/pdfs/resourcelib/BakerLarsenWiley.pdf

6.0 Developed By

Biomedical Technology, Hamilton Health Sciences;
Biomedical Engineering, St. Joseph's Hamilton

7.0 In Consultation With

Medical Affairs/Risk Management, Public Relations, Document Management, Biomedical Technology, Professional Affairs, ICT, Clinical Support and Hospital Services, Regional Purchasing, St. Joseph's Healthcare,

8.0 Approved By

Integrated Vice President, Clinical and Hospital Services, HHS-St. Joseph's
Reviewed 2010:
Manager, Biomedical Engineering
Revision 2011 Approved by:
Manager, Biomedical Engineering
ICT, Manager Infrastructure and Project Management

Appendix: Background and Rationale

Hamilton Health Sciences (HHS) is dedicated to maintaining a safe patient care environment. As part of this philosophy, we acknowledge that certain radio frequency (RF) transmitters, such as, cellular telephones, two-way radios, wireless networking, mobile computing devices, and other wireless transmitters, may, on extremely rare occasion, affect certain susceptible electro-medical devices. However, HHS recognizes that effective and timely communication is essential to optimum health care. This indicates the need to adopt new technologies for communication and the need to provide patients and visitors with increased flexibility..

A substantial increase in the production and use of communication devices has taken place over a short number of years. As a result, there have been many studies investigating the effects of EMI on medical devices including the development of EMC standards for medical device manufacturers. However, there has been no recognition for any particular study resulting in regulatory control in hospitals. This policy comes with references and supporting documentation from government, radio frequency experts, ad hoc testing, peer facilities, publications, and Internet sources.

Mandatory Reporting of Regulated Health Professionals to Regulatory Bodies Guideline: Incapacity, Incompetence, Sexual Abuse/Assault Policy

Hamilton Health Sciences	POLICY MANUAL
Posting Date: 2012-04-24 **Posting History Dates:**	
Title: IPC - Mandatory Reporting of Regulated Health Professionals to Regulatory Bodies Guideline: Incapacity, Incompetence, Sexual Abuse/Assault	

Applies to: All Regulated Health Professionals (RHPs) practicing at Hamilton Health Sciences and their reporting managers and directors.
Note: Does not include Physicians, Midwives and Dentists

1.0 Purpose & Goals Description

1.1 The Regulated Health Professions Act (RHPA) imposes reporting obligations on Hamilton Health Sciences (HHS) as a facility operator. The obligation is to report to the appropriate regulatory body, incompetence and/or incapacity, sexual abuse/assault and/or termination (as defined in regulation) of regulated health professionals practicing at HHS.

1.2 The purpose of this guideline is:

1.2.1 To provide a process to guide decision-making in determining when and if an RHP meets the facility operator criteria for a mandatory report of incompetency, incapacity or sexual abuse/assault to a regulatory body as defined in the Regulated Health Professions Act (1991, 2009).

1.2.2 To define the roles and responsibilities of all HHS RHPs in the mandatory reporting process.

1.2.3 To establish an objective, fair, transparent and timely process to assess for reportable incompetence or incapacity (as defined by RHPA) and sexual abuse/assault which can be consistently applied to all RHPs practicing at Hamilton Health Sciences.

1.3 Outcomes

The outcomes to be enabled through implementation of these guidelines are:

1.3.1 A process of determining reportable incompetence and/or incapacity and sexual abuse/assault which meets timelines stated in the RHPA (30 days).

1.3.2 A consistent point within an investigation and/or review process from which the reporting timeline is measured.

1.3.3 The process to be taken when potential incompetence and/or incapacity and sexual abuse/assault is identified

1.3.4 Communication of the process to all facility regulated health professionals, program management, union representatives, risk management, employee health and human resources.

1.3.5 Competency and/or capacity reviews compliant with professional, human rights, human resource and other relevant standards and legislation.

1.3.6 A process guideline which meets regulatory requirements while minimizing conflict with legislation, human resources policies, and duty to accommodate requirements.

1.3.7 A process by which safety of reporting staff or other parties to an investigation are addressed.

2.0 Equipment/Supplies

NA

3.0 Policy

3.1 The mandatory obligation to report to an RHP's regulatory college arises when there are reasonable grounds to believe

- that a health professional is incompetent or incapacitated and that his/her ability to practice safely is impacted **or**

- that an RHP has sexually abused or is suspected of having sexually abused a patient.

3.2 Prior to making a mandatory report to a regulatory college for incompetence or incapacity, a two-part test is required. The test includes:

- **Incompetence:**
  1. demonstrated lack of knowledge, skill and judgment that
  2. impacts on their ability to practice safely to the extent that there is a need to restrict practice.
- **Incapacity:**
  1. condition or disorder that
  2. impacts on their ability to practice safely to the extent that there is a need to restrict practice.

3.3 Before a report is mandated, both aspects of the test need to be satisfied based on the RHP's current condition.

3.4 In situations where the RHP is complying with certain modifications to his/her practice, such as return to work agreements, and there is no impact on patient safety, there is no obligation to report. In the best case scenario, this will have been confirmed by the RHP, either through voluntary self-reporting or admission when confronted with their practice (Miller Thomson LLP, 2009).

3.5 A mandatory report to the regulatory body under this provision should not be viewed as punitive. Often the RHP will have self-reported a condition which the organization and the RHP will seek to monitor and manage together. The report to the regulatory body should be viewed as a part of a collaborative process as the regulator will see its role as assisting the RHP for the purpose of protecting the public.

3.6 Sexual Abuse/Assault:

3.6.1 Sexual abuse/assault is considered a criminal offense under the Criminal Code of Canada (1985) Section 272(1). As such, victims of sexual abuse/assault have the right to report to their local authorities.

3.6.2 When an employer or other health care provider becomes aware that an RHP may have sexually abused/assaulted a patient, they are required by law to report to the RHP's regulatory body. When suspected sexual abuse/assault is reported to the regulatory body, the patient's name cannot be provided to the regulatory body unless the patient has given his or her written consent.

3.7 Termination:

3.7.1 Employers and facility operators have a mandatory obligation to inform the appropriate regulatory body when they terminate, or intend to terminate, for cause the employment of an RHP.

3.8 Reporting Triggers

3.8.1 A report would be triggered in instances of incompetence and/or incapacity, sexual abuse/assault and/or termination or intent to terminate (see Definitions) validated by a thorough investigation of the facts (see

responsibilities of Clinical Manager/Director).
Note: These instances could be identified through such measures as, but not limited to, patient/family or staff complaints or observations, results of clinical manager and/or Human Rights and Diversity Specialist investigations, occurrence reports, performance appraisals, and/or failed learning plans or competency reviews.

3.9 Timeline for Reporting

3.9.1 Once the investigation is complete and the determination of incompetence and/or incapacity has been made, the report is to be submitted in writing to the designated person (e.g., Executive Director/Registrar)of the RHP's respective regulatory body within 30 days.

3.9.2 If the clinical manager is unable to obtain information from a staff member to complete the investigation, the report is to be completed with the information available and submitted to the regulatory body.

3.9.3 The report is to be signed by both the reporting manager/director and the appropriate Chief of Professional Practice.

3.9.4 **Exceptions**: A report must be filed immediately if there are reasonable grounds to believe that the incompetence or the incapacity of the RHP is likely to expose a patient to harm or injury or that the RHP will continue to sexually abuse/assault a patient or patients and there is an urgent need for intervention (RHPA, 2007, c.10, Schede. M, s. 62[1]).

3.10 Responsibilities of Clinical Manager or Director

The Clinical Manager and/or Director:

3.10.1 Determines, in collaboration with the appropriate Chief of Practice and Human Resources, if the suspected incompetency and/or incapacity issue or sexual abuse/assault of the RHP poses a threat to patient or staff safety, and if so,

- informs the RHP of the concern and the investigatory process that will take place,
- consults with Human Resources and
- places the RHP on leave with pay pending the results of the investigation.

3.10.2 Offers all employee(s) involved in reporting/informing a safety plan if appropriate. The safety plan is created with each affected employee to ensure that his/her individual safety needs are met while in the workplace.

3.10.3 Performs preliminary investigation of the facts. These may be identified through such measures that may include, but are not limited to, patient/family or staff complaints, Human Rights and Diversity Specialist reports, observations, occurrence reports, performance appraisals, failed learning plans or competency reviews.

3.10.4 Ensures that all facts identified that are related to alleged incompetence or incapacity, sexual abuse/assault, termination or intent to terminate for cause are documented and that progressive discipline practices set out by Human Resources policy are followed.

3.10.5 Documents all events and investigatory findings and other relevant information acquired.

3.10.6 Based on the results of the full investigation, meets with the RHP and other stakeholders to determine if the individual has insight into, or an explanation for any of the allegations that have been validated by the

investigation.

3.10.7 Considers the need for mandatory reporting
- if the RHP demonstrates a lack of insight into the incompetence or incapacity problem(s) identified in the investigation or
- if the goals of any prior agreed upon educational learning plan based on similar fact has not been achieved.

3.10.8 Summarizes and communicates the competency or incapacity issues identified, any suspected sexual abuse/assault, termination or intention to terminate for cause identified, to Human Resources, the Program Director, the Chief of Professional Practice and Employee Health (as appropriate)

3.10.9 Where an action identified as a result of the investigation includes the need for a competency review, collaborates with the Chief of Professional Practice to develop the content and process for the review.

3.10.10 Refers to Employee Health where the action/outcome of the investigation confirms an incapacity issue related to health.

3.10.11 Communicates the plan for a competency or capacity review to the RHP (timelines, type of evaluation, preparation required, when results will be communicated), and negotiates resources and/or support that may be needed (study time, consultation with educator or others)

3.10.12 Schedules a competency review if required.
Maintains paid leave of absence if indicated by the results of the competence or capacity investigation.

3.10.13 If the outcome of the competency or capacity reviews indicates a risk to safe patient/family care, prepares in collaboration with the Chief of Professional Practice, a report to the regulatory body for submission within the required 30-day timeline.

3.10.14 Implements a mandatory report for all of the following: termination or intention to terminate and suspected sexual abuse/assault. **Recognize that the respective regulatory bodies are required to disclose and share this report with the health professional.**

3.10.15 Retains all documentation supporting the investigation and the mandatory report.

3.11 Responsibilities of Chief of Professional Practice

The Chief of Professional Practice:

3.11.1 If indicated, offers any reporting employee(s) a safety plan. The safety plan is created with each affected employee to ensure that his/her individual needs are met while in the workplace. The safety plan is documented and may be communicated to appropriate stakeholders.

3.11.2 Recommends appropriate competency evaluator(s) (internal and/or external).

3.11.3 Identifies appropriate resources (human and material) to evaluate competency (e.g. case scenarios, competency assessment tools, clinical observation check list, written test)

3.11.4 Communicates the final plan for competency review to the RHP, Manager or Director, Human Resources, educator, union representative and other stakeholders where applicable.

3.11.5 Reviews the results of the competency review to determine if it meets the criteria for mandatory reporting.

3.11.6 Documents all relevant results and related information.

3.11.7 If indicated, collaborates with the Director or Clinical Manager to draft a

mandatory report to the RHP's regulatory body.

3.11.8 Consults with the regulatory body if needed and confirms mandatory reporting obligations are met.

3.11.9 Provides advance notice to VP Professional Affairs and Chief Nursing Executive of impending mandatory report of incompetency, incapacity or suspected sexual abuse/assault, termination or intention to terminate.

3.11.10 Signs and submits to the RHP's regulatory body, the mandatory report of incompetency and/or incapacity, suspected sexual abuse/assault, termination or intention to terminate for cause

3.11.11 Maintains a profession-specific inventory of mandatory reports submitted to the regulatory body.

3.12 Responsibilities of Regulated Health Professionals

Each RHP employed at HHS:

3.12.1 Participates in a recommended competency review process.

3.12.2 Accepts referral to Employee Health for follow-up when capacity issues are identified.

3.12.3 Identifies any concerns regarding competency or incapacity of other RHPs to the reporting Manager.

3.12.4 Reports to a clinical manager, director, administrator and/or appropriate regulatory body any awareness or suspicion that an RHP may have sexually abused/assaulted a patient.

3.12.5 Communicates any safety concerns regarding patients, themselves or other staff to their reporting manager or Chief of Professional Practice and participates in the development of a safety plan.

3.13 Responsibilities of Human Resources Representative

The HR representative for the Program where the review/investigation is being conducted:

3.13.1 Provides advice related to implications of the competency or capacity review and mandatory reporting process with regard to labour relations.

3.13.2 Collaborates with Director and/or Clinical Manager to determine next steps if indicated.

3.13.3 Participates in the creation of safety plans as required. Safety plans are created with employees to ensure that their individual needs are met while in the workplace. The safety plan is documented and may be distributed to appropriate stakeholders.

4.0 Procedure

See Appendix A Flow Chart

5.0 Definitions

Incompetence –Defined in section 52 of the RHPA (2009) Code to mean that "the member's professional care of a patient displayed a lack of knowledge, skill or judgment of a nature or to the extent that demonstrates that the member is unfit to continue to practice or that the member's practice should be restricted."

Incapacity – Defined in the RHPA (2009) Code which states that "the member is suffering from a physical or mental condition or disorder that makes it desirable in the interest of the public that the member's practice

be subject to terms, conditions or limitations or that the member no longer be permitted to practice."

Reasonable Grounds – Is more than just rumour or conjecture, of either (1) a member's lack of knowledge, skill or judgment or (2) a member's mental or physical condition or disorder. In the best case scenario, this will have been confirmed by the member themselves, either through voluntary self-reporting or admission when confronted about their current practice.

Facility Operator – "any person who operates a facility" where one or more regulated health professionals is practicing.

Health Care Providers – persons who, by education, training, certification, or licensure are qualified and engaged in exercising skill or judgment or providing a service related to:

(a) the preservation or improvement of the health of individuals, or

(b) the treatment or care of individuals who are injured, sick, disabled or infirm.

Regulated Health Professionals – health care providers whose practice is regulated under the Regulated Health Professions Act and associated discipline-specific acts or other comparable legislation.

Professional Staff – As per the Public Hospitals Act, Regulation 956, Professional Staff refers to credentialed physicians, dentists and midwives

Sexual Abuse/Assault Sexual Abuse/Assault – Defined in the Criminal of Code Canada 272(1) This is a very broad definition that illustrates what would constitute non-consensual sexual activity. It recognizes that people cannot always speak up and say no. They may be disabled or frozen in some way from speaking up; they may be intimidated or coerced into saying yes when they don't want to, they may be too afraid to say no. According to the Criminal Code of Canada (1985) there is no consent in any of these scenarios. The Criminal Code of Canada (1985) views sexual assault as an assault that is sexual in nature. The sexual assault offenses include: sexual assault; sexual assault with a weapon, threats to a third party or causing bodily harm; and aggravated sexual assault.

272(1) Sexual assault with a weapon, threats to a third party or causing bodily harm-
Every person commits an offense who, in committing a sexual assault,

a. Carries, uses or threatens to use a weapon or an imitation of a weapon;
b. Threatens to cause bodily harm to a person other than the complainant
c. Causes bodily harm to the complainant; or
d. is a party to the offense with any other person

Sexual abuse/assault occurs when a health professional:

- has physical sexual relations with a client/patient

- touches a client/patient in a sexual manner
- behaves in a sexual manner with a client/patient; and/or
- makes remarks of a sexual nature to a client/patient.

Safety plan – a plan of action developed to protect a staff member whose personal safety at work has been identified as at risk. The plan is developed collaboratively with the at-risk employee, his/her manager, human resource representation and union representation (as applicable).

Termination – Under the RHPA (1991, 2009), Schedule 2 Section 85.5 (1), the type of termination which requires a mandatory report is one where the employment relationship between the employer and the employee is ended for reasons of professional misconduct, incompetence or incapacity.

Intention to Terminate - Under the RHPA (1991, 2009), Schedule 2 Section 85.5 (2), a mandatory report is also required in the situation where there are plans to end the employment relationship (terminate) for reasons of professional misconduct, incompetence or incapacity, but the member/employee resigns prior to being terminated.

6.0 Cross References

CORP – Values Based Code of Conduct Protocol
HR – Progressive Discipline Policy
HR – Hamilton Health Sciences Chemical Dependency Program Protocol
HR – Personal relationships between staff members and clients
HSW – Violence in the Workplace Policy
ADMIN – Harassment Protocol

7.0 External References

Bill 171, Health System Improvements Act, 2007
Smitherman, Hon George Minister of Health and Long-Term Care

Criminal Code of Canada (R S C. 1985). Department of Justice Canada. http://laws.lois.justice.gc.ca

Colleges Legislated under the *Regulated Health Professions Act, 1991*
http://www.health.gov.on.ca/english/public/program/pro/procol_dt.html

Mandatory Reporting: A process guide for employers, facility operators and nurses. College of Nurses of Ontario, June 2009.

Communiqué for the Health Industry: Ontario's New Reporting Obligations for Facility Operators regarding Incompetence and Incapacity. Jennifer Hunter, Miller Thompson LLP Barristers and Solicitors. October 21, 2009

Government of Ontario (1990). Public Hospitals Act
http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90p40_e.htm

College of Nurses of Ontario (2009). Mandatory Reporting

http://www.cno.org

9.0 Developed By

Chiefs of Nursing Practice
Chief of Respiratory Therapy Practice
Clinical Managers
Patient Relations and Risk Management Specialist
Human Resources Consultant
Human Rights Specialist

10.0 In Consultation With

St. Joseph's Health Care Hamilton
Medical Affairs

11.0 Approved By

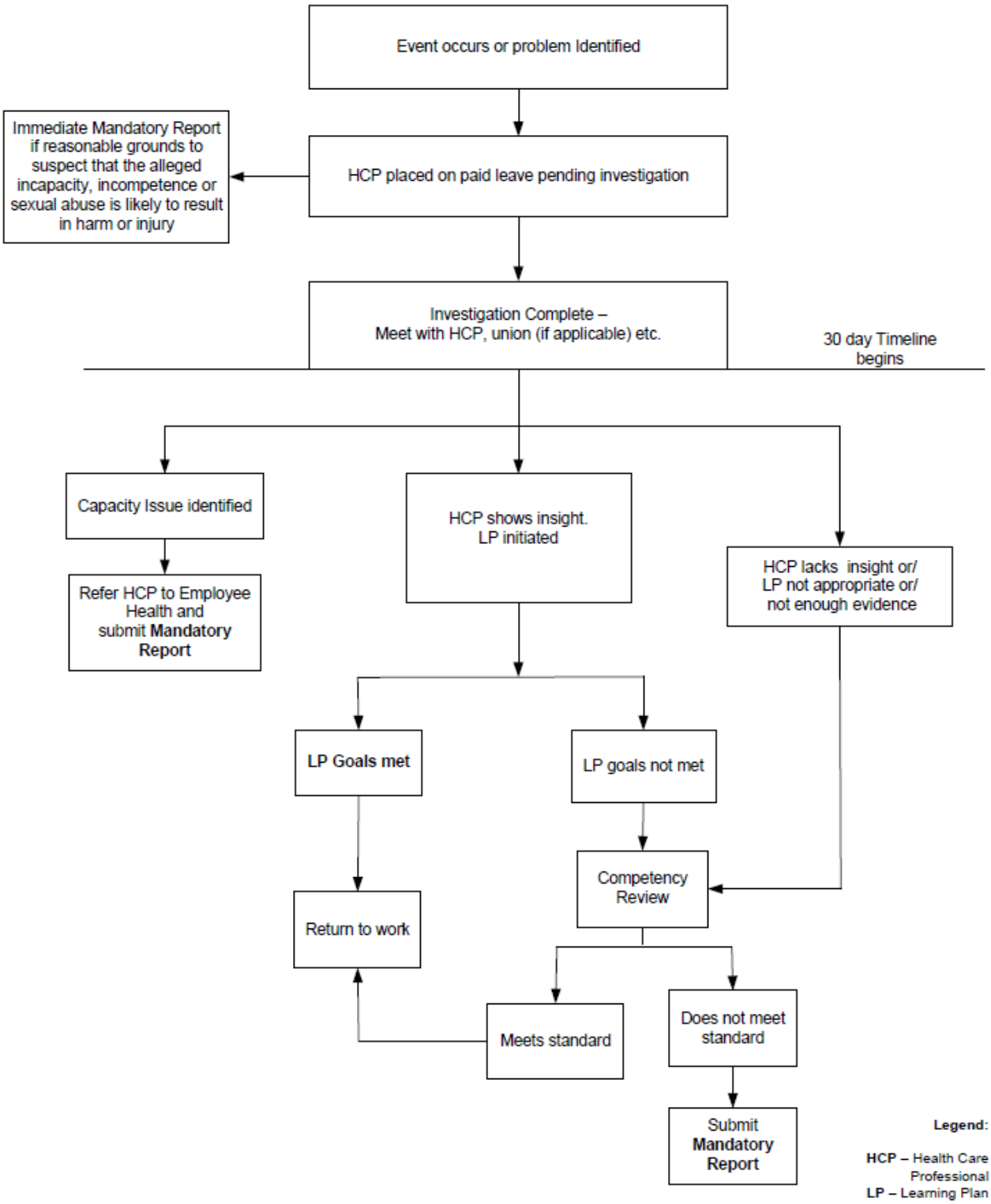
PAC

Keyword Assignment RHPA, Human Resources, progressive discipline, safety, risk

END OF DOCUMENT

For internal use only at HHS. Persons reviewing a hard copy of this document should refer to the electronic version posted in the Policy Library to ensure this copy is current.

Appendix
Mandatory Reporting Flowchart



Mandatory Reporting Form for Facility Operators

Appendix B

Date of Report:

This form is for Facility Operators to report (Please check all applicable boxes):

If a health professional is:

- ☐ Incompetent
- ☐ Incapacitated

Name of facility/agency/employer:

Street Address:

City:

Postal code:

Contact Person:

_____

Name

_____

Position

_____

Phone

_____

Fax

_____

Email

Type of setting (choose one):

- □ Acute inpatient
- □ Acute outpatient
- □ ALC
- □ Palliative
- □ Mental health
- □ Other:

Nature of Report:

- □ Incompetence
- □ Incapacity

Member's Name:

Date of hire:

Termination or resignation date:

Address (if known)

Employment Status:

- □ Full-time
- □ Part-time
- □ Casual

Type of shift (Days/Nights/Weekends):

Unit/practice that member worked:

Member's Role

Smoke Free and Tobacco Free Policy

HAMILTON HEALTH SCIENCES	Page 1 of 103
Posting Date: 2012-12-17 *Posting History Dates: 2010-12-08*	
Title: Smoke Free and Tobacco Free Policy	

Applies to: All patients/clients, HHS staff, members of the medical, dental and midwifery staff, medical residents, learners, volunteers, members of the Board of Directors, visitors, contractors, hospital affiliates (including contract and agency staff), and all other individuals who attend Hamilton Health Sciences' sites and properties.

Hamilton Health Sciences(HHS) is committed to providing a safe, healthy and comfortable environment for our patients, visitors, staff, volunteers, learners and all individuals who enter our premises.
In accordance with our Mission "to provide excellent health care for the people and communities we serve" and the Strategic Goal "to have a healthy working environment", Hamilton Health Sciences is a Smoke-Free organization.

1.0 Purpose

1.1 To detail how HHS provides a smoke free environment across all HHS sites and properties.

1.2 To meet all legislative requirements such as the "Smoke Free Ontario Act (2006)" and support the Ontario Clean Air and Healthy Workplace Initiatives.

1.3 To identify support for patients and employees who request assistance in their efforts to attain a smoke-free lifestyle.

2.0 Definitions

Tobacco Products:
For the purposes of this policy the term "tobacco products" refers to tobacco in any processed or unprocessed form that may be smoked, inhaled, chewed, or dissolved in the mouth including but not limited to snuff, chewing tobacco, cigarettes, cigars, pipe tobacco, water pipes, dissolvable tobacco; and non-tobacco products including but not limited to electronic cigarettes, herbal cigarettes, marijuana.

Smudging Ceremony:
The smudging ceremony is a spiritually healing ceremony performed by some Aboriginal people and may be requested by Aboriginal patients and their families receiving health services at Hamilton Health Sciences.

Hamilton Health Sciences' Sites and Properties:
This includes all sections/areas of hospital buildings, the exterior grounds, and parking areas (garages and lots – including inside a personal vehicle while on hospital property). While adjoining bus shelters are city owned, smoking may be prohibited under the Smoke Free Ontario Act.

3.0 Policy

3.1 HHS Sites and Properties

Hamilton Health Sciences prohibits the use of tobacco products on all of its sites and properties.

This policy applies to all instances where the person is located on hospital property.

Special Exemption: As defined in the Smoke-Free Ontario Act, special exemptions will be considered at the request of an Aboriginal who is an **inpatient** for the traditional use that forms part of a spiritual ceremony. Provision of an indoor area is covered in the smudging protocol. The MAC Smudging Ceremony Protocol is to be referred to and followed in such circumstances.

3.2 Sale of Tobacco Products

The sale of cigarettes, tobacco and tobacco products at HHS is prohibited.

3.3 Expectations

All HHS Staff, members of the Medical, Dental and Midwifery Staff, members of the HHS Board of Directors, Learners, Medical Residents, Contract Staff, Contractors and Volunteers are expected to continually support and represent Hamilton Health Sciences' commitment to maintain a smoke-free environment.

3.4 Responsibilities

3.4.1 **Staff**:

(i) Staff are expected to model our HHS values - particularly Respect, Caring and Accountability - with their compliance and enforcement of this policy.

(ii) Staff are not to accompany patients or clients to smoke or assist them with smoking. Staff are to advise a medically unstable patient not to leave the unit/facility to smoke. Should the patient insist on leaving, staff shall document the patient's decision to leave against medical advice. (Refer to the consent policy section 2.6)

(iii) Staff providing services in a client home may request a person not to smoke in his/her presence. Should a client not meet such a request, the staff member is to contact their manager to discuss alternatives. Staff are not to smoke in the presence of patients and clients.

(iv) Clinical Staff are to become familiar with and utilize the 5A Minimal Contact Intervention approach (Ask, Advise, Assess, Assist, and Arrange) to smoking cessation for patients.

(vi) Smoking cessation programs are available to all staff and their families through recommended community-based smoking cessation programs (such as Smoker's Helpline).

3.4.2 **Patients**:
(i) Patients are not permitted to use tobacco products on HHS' sites and properties.

(ii) Prior to and upon admission, all patients will be informed that HHS is a Smoke-Free Hospital.

(iii) Upon admission, the relevant aspects of the Smoke-Free Policy will be reviewed with all patients and their families, or with those individuals who accompanying a patient. Staff will inquire whether the patient uses tobacco products and note the answer in the patient's health record.

(iv) Staff in clinical areas will educate inpatients who smoke regarding smoking cessation supports, including but not limited to counseling and nicotine replacement therapies.

(v) Patients are not permitted to leave hospital premises to smoke while wearing or transporting oxygen or any other hospital equipment that could be a safety issue (flammable -related to ignition or heat as a result of using tobacco products). (refer also to 3.4.1(ii)

(vi) Inpatients who currently use tobacco products will be offered smoking cessation support including pharmacotherapy and information.

(vii) Patients may choose to give tobacco products to a friend or family member for safekeeping or ask HHS staff to dispose of the products. Staff are encouraged to ensure safe storage of ignition materials (lighters, etc.) Whenever possible ignition materials are to be given to a friend or family for safekeeping.

(viii) Outpatients will be asked to leave tobacco products in their vehicles or preferably at home while attending at HHS locations.

3.4.3 **Visitors:**
(i) Visitors to Hamilton Health Sciences are not permitted to use tobacco products on HHS' sites and properties.

3.5 Compliance and Enforcement

3.5.1 Failure to comply with the Smoke Free Ontario Act, by any person located on HHS sites or properties, may be subject to fines as issued by a City of Hamilton Tobacco Enforcement Officer, as outlined in the Act.

3.5.2 Failure to comply with this policy, by any Staff, Members of the Professional and Medical Staff, Medical Residents, Contractors, Hospital Affiliates (contract and agency staff) and Volunteers, will result in disciplinary action up to and including termination of employment, privileges, or contract with HHS.
Please refer to the Human Resources Progressive Discipline Policy.

3.5.3 If staff feel comfortable, equipped, and safe to remind patients, visitors, and colleagues about the new smoke-free policy, they are encouraged to do so in a manner that reflects the HHS values.

3.5.4 **Patients:**

(i) Patients who do not comply with this policy are to be respectfully reminded of the policy and requested to extinguish the tobacco product immediately. The patient's unit is to be notified and the incident documented on the patient's record. Smoking cessation counseling and/or withdrawal management therapy is to be offered.

(ii) If a patient continues to not comply with the policy, the healthcare team should have a conference to discuss options and resources to support patient safety and compliance. Social Work, Patient Relations/Risk Management, the Clinical Manager, Security, and health care team will develop a plan of action.

3.5.5 **Visitors, Students, Learners:**

(i) A respectful reminder is provided to those who are visiting and fail to comply with this policy. If the visitor fails to comply, he/she is escorted off the HHS property by security.

(ii) Subsequent occurrences may result in the issue of a Trespass Order under the Trespass to Property Act for failing to comply with Provincial Legislation if breaching the Smoke Free Ontario Act. The matter is forwarded directly to an Inspector, as outlined in the Smoke-Free Ontario Act, for enforcement.

4.0 Documentation

Discussions and events related to any smoking issues are to be documented in the patient/client's clinical record.

5.0 Cross References

MAC Smudging Ceremony Protocol
HR Progressive Discipline Policy
HHS Values Based Code of Conduct
HHS Mission, Vision and Values and HHS Strategic Goals
MAC Consent, Withdrawal or Refusal of Consent for Treatment Policy

6.0 External References

City of Hamilton Smoking By-law No. 02-054 (and as amended).
The Tobacco Control Act (Ontario 1994) (and as amended)
Smoke-Free Ontario Act (Ontario 2006) (and as amended)
Trespass to Property Act
Maps of all HHS Sites clearly outlining boundaries.

Smoking Cessation Programs information for patients (as applicable) and the applicable links/information for smoking cessation supports for staff.

7.0 Developed By/In Consultation With

Policies and Procedures Working Group – Smoke Free Initiative
Public Health
Canadian Cancer Society's Smoker's Helpline
Volunteer Services
Union representatives

8.0 Approved By

- Policies and Procedures Working Group – Smoke Free Initiative
- Smoke Free Initiative Steering Committee
- Executive Team
- Chief of Staff/Medical Advisory Council (MAC)
- Professional Advisory Committee (PAC)
- Joint Health and Safety Committees
- Site Councils

Keyword Assignment smoke, smoking, smoke free, tobacco, smudging

Violence in the Workplace Policy

Hamilton Health Sciences	HSW MANUAL
Posting Date: 2012-05-15 ***Posting History Dates:*** 2007-03-09; 2008-10-01; 2010-09-10; 2011-10-27; 2012-05-15	PAGE 1 OF 4
Title : **HSW - Violence in the Workplace Policy**	

Applies to: All Hamilton Health Sciences (HHS) workers, hospital affiliates, members of the Medical, Dental, and Midwifery staff, Board of Trustees, learners, visitors, clients, delivery persons and volunteers.

Hamilton Health Sciences (HHS) is committed to the prevention of workplace violence by providing an environment where people feel personally safe and not exposed to undue threat, harassment, abuse or violent situations. Harassment and violence in any form, including domestic violence, is a serious infringement upon the rights of the Hamilton Health Sciences community. As such, HHS will make reasonable efforts to prevent and remedy the effects of harassment and/or violence and provide corrective action if/when appropriate.

1.0 Purpose & Goals Description

1.1 To ensure that:

- Workers and Hospital affiliates are aware of their responsibilities and rights with respect to such incidents.
- Workplace violence occurrences against workers are mitigated or dealt with quickly and effectively.
- Workers affected by workplace violence are supported.
- Workers who are subject to domestic violence may impact themselves or their colleagues in the workplace, will identify their concerns to their manager so that safety issues may be addressed.
- The rights and obligations of collective agreements or those with supervisory responsibilities are not contravened.
- The personal dignity of all parties concerned is protected.
- Everyone is expected to uphold this policy and work together to prevent workplace violence.

2.0 Equipment/Supplies

None

3.0 Policy

3.1 Hamilton Health Sciences is committed to the prevention of workplace violence and is ultimately responsible for worker health and safety. See DEFINITIONS – Workplace Violence.

3.2 Violent behaviour in the workplace is unacceptable from anyone. All individuals at Hamilton Health Sciences are to maintain a violence-free work environment by taking responsibility and accountability for their behaviour.

3.3 The Violence in the Workplace program supports the Violence in the Workplace policy. The program includes measures and procedures to protect workers from workplace violence, a means of summoning immediate assistance and a process for workers to report incidents or raise concerns.

3.4 Workers, leaders, unions, physicians and learners will provide a nonjudgmental and supportive environment for workers to identify risks and concerns.

3.5 Hospital workers, physicians and learners found to engage in conduct constituting workplace harassment or violence are subject to remedy, including developmental strategies and/or progressive discipline up to and including termination of employment or withdrawal of privileges.

3.6 Patients, clients/outpatients or visitors are informed of their responsibility to maintain a violence free environment. The consequences of conduct constituting harassment or violence will result in sanctions up to and including removal of visitation rights or discharge, if appropriate.

3.7 The assessment and maintenance of a safe environment for patients and workers ensure that the service of any involved unit is not compromised. If necessary, interim measures are provided to secure a safe environment. These measures are determined and implemented by the appropriate unit manager/supervisor in consultation with the unit's Vice President, Security, Health Safety and Wellness and other relevant parties (i.e. unions, Joint Health and Safety Committees, Chiefs of Professional Practice, professional associations or colleges).

3.8 Individuals have the right to seek alternative processes through their union, Human Resources, Patient Relations/Risk Management, HHS Office of Human Rights, externally through the Ontario Human Rights Commission, Ministry of Labour, Police Services and/or the courts.

3.9 HHS and McMaster University may, where appropriate, share all relevant information about the conduct of University-affiliated HHS individuals (e.g. faculty members, staff, students, learners, fellows or residents) and jointly consider, investigate or determine any complaint brought forward.

3.10 All HHS individuals have a right to submit a workplace violence complaint. Interference with an investigation or retaliation against a complainant or witness, whether the complaint is substantiated or unsubstantiated, may itself result in disciplinary action. Interference or retaliation may include, but is not limited to, direct contact between the parties, shunning, reassignment, spreading of rumors and breeches in confidentiality.

3.11 Employer Responsibilities

3.11.1 Hamilton Health Sciences as the employer, is to ensure that this policy and the supporting program are implemented and maintained and that all workers and supervisors have the appropriate resources, information and instruction to protect themselves.

3.12 Supervisor Responsibilities

3.12.1 Supervisors are to adhere to this policy and the supporting program. Supervisors are responsible for ensuring that measures and procedures are

followed by workers and that workers have the information that they need to protect themselves.

3.13 Worker Responsibilities

3.13.1 Every worker must work in compliance with this policy and the supporting program. All workers are encouraged to raise any concerns about workplace violence and to report any violent incidents or threats.

3.14 Preventative Education and Training

3.14.1 HHS recognizes that identification, prevention and de-escalation of violent/threatening situations require ongoing education and training. HHS supports this in order to creat an environment that promotes the dignity and lawful treatment of all, as a tool to prevent and resolve incidents. Training may range from individual to group coaching and may also include CPI (Crisis Prevention Intervention) and/or GPA (Gentle Persuasion Approach) training as assessed by individual programs and departments.

4.0 Definitions

Workplace Violence

- The exercise of physical force by a person against a worker, in a workplace, that causes or could cause physical injury to the worker;
- An attempt to exercise physical force against a worker, in a workplace, that could cause physical injury to the worker; or,
- A statement of behaviour that is reasonable for a worker to interpret as a threat to exercise physical force against the worker, in a workplace, that could cause physical injury to the worker.

Domestic Violence(Also referred to as domestic abuse or spousal abuse)

- Can occur when a family member, partner or ex-partner attempts to physically or psychologically dominate another. Domestic violence occurs in all cultures; people of all races, ethnicities, religions and classes can be perpetrators of domestic violence. perpetrated by both men and women

Workplace Harassment

- Engaging in a course of vexatious comment or conduct against a worker in a workplace that is known or ought reasonably to be known to be unwelcome (e.g. Verbal abuse, threatening behaviour, written or verbal threats, physical assault)

5.0 Cross References

ADMIN – Harassment Protocol
ADMIN - Whistleblowing Protocol
EDM – Code White Protocol Flowchart Forms Worksheets
CORP – Values Based Code of Conduct Protocol

6.0 External References

Occupational Health and Safety Act

Workplace Violence Legislation (Bill 168)
Workplace Violence and Harassment: Understanding the law
All available @ www.labour.gov.on.ca

7.0 Developed By

Health, Safety and Wellness
Human Rights
Security
Hurst Place
Professional Affairs

8.0 In Consultation With

ONA
OPSEU
CUPE
Joint Health and Safety Committees

9.0 Approved By

Director – Health, Safety and Wellness
Manager – Safety Services

Keyword Assignment *Violence, harassment, domestic, rights, safe,*

ID Badges

Students must wear a photo ID badge in clear view at all times. Students with photo ID badges from McMaster University and Mohawk College may wear these badges at HHS. All other students will require a Hamilton Health Sciences ID badge. Arrangements will be made if required.

Library Services

Hours
Monday to Friday – 0830 to 1630 hours – **closed** Saturday, Sunday and stat holidays.

Services
* wide range of journals and texts available
* titles not available on-site can be ordered through the Hamilton and District Health Library Network
* databases on CD-ROM

Locations
Staff and students may access a library at any one of these locations:

Hamilton **General** Hospital:	293 Wellington Street North, Suite 125 Ext.: 44248 or 44247
Juravinski Hospital and Cancer Centre:	1st floor, 90 Wing, Section E Ext.: 42579 or 42099
A Resource Centre is available at **St. Peter's** Hospital:	Juravinski Research Centre Ext.: 12476

Students may also be interested in visiting McMaster University Health Sciences Library. This library is operated by McMaster University and is located at McMaster University Medical Centre, Section 2B, Ext. 24168.

Parking

Chedoke
Parking Office Ext. 77754 - Wilcox Building 1st Level, Monday to Friday, 8 a.m.-4 p.m.

General
Parking Office Ext. 44061 - Victoria Ramp, Level B, Monday to Friday, 8 a.m.-8 p.m.

Juravinski Hospital and **Cancer Centre**
Parking Office Ext. 42354 - Concession Ramp, last turn before exit (orange door), Monday to Friday, 8 a.m.-8 p.m.

McMaster
Parking Office Ext. 76156 - Parking Garage, 1PG1, red section next to Main Street exit, Monday to Friday, 8 a.m.-8 p.m., weekends: 10 a.m.-4 p.m.

St. Peter's
Parking inquiries can be made at the St. Peter's Hospital Gift Shop Ext. 12302 - Lower Level West, Monday to Friday, 9:30 a.m.-3:30 p.m.

West Lincoln
Parking tokens are available through Switchboard between 8 a.m. and midnight .

Keeping in mind our hospital's values of respect, caring, innovation and accountability, please be patient and considerate when using the parking facilities. Consider these ParkSMART! tips to benefit patients, visitors and others:

"**S**" - Stay between the lines - don't double park, block lanes or leave your car in undesignated areas.

"**M**" - Make room for patients - park in far-flung or high levels so patients don't have to go far.

"**A**" - Allow time to park - be patient.

"**R**" - Respect others who are struggling to cope with the parking situation.

"**T**" - Try other ways of commuting - car pool, use public transit, bike or blade when possible.

Please be sure to respect parking spaces designated for patient and visitor use by not parking in them. If you are experiencing difficulty parking, please contact the Parking Office at your site.

Hospital Addresses

To access any of these sites by telephone, call 905-521-2100

Chedoke Hospital Site
Sanatorium Road
Box 2000
Hamilton, Ontario L8N 3Z5

Hamilton General Hospital Site
237 Barton Street East
Hamilton, Ontario L8L 2X2

Juravinski Hospital Site
711 Concession Street
Hamilton, Ontario L8V 1C3

MUMC/McMaster Children's Hospital Site
1200 Main Street West
Hamilton, Ontario L8N 3Z5

Ron Joyce Children's Centre
Wellington Street
Hamilton, Ontario

St. Peter's Hospital Site
88 Maplewood Avenue
Hamilton, Ontario L8M 1W9

West End Urgent Care Centre
690 Main Street West
Hamilton, Ontario L8M 1W9

West Lincoln Memorial Hospital Site
169 Main Street East
Grimsby, Ontario L3M 1P3

www.hamiltonhealthsciences.ca

Patient Complaints

Here's how to communicate with angry people

Don't react with anger

- Remember that they are angry at a situation, don't take comments personally.
- Focus on understanding the problem, not reacting to the person's behaviour.

Communicate caring

- People are often angry because they feel out of control.
- They need reassurance that you care and are willing to listen.
- Tell them you'd like to help. Ask them how you can help.
- Emphasize what you do, not what you can't do.
- Watch your body language, and your tone of voice.
- Are you breathing quickly? Breath slowly and deeply to relax yourself.

Ask for information

- Asking angry people for information helps to move them from childish angry behaviour to adult problem-solving behaviour.
- Asking caring questions give the message that you want to understand.
- Use the Hamilton Health Sciences Complaint Form on Public Folders to write down the patient's complaint (it helps the patient realize you're listening and taking them seriously).

Personalize

- Stop doing everything else and focus on the person.
- Use their name, in a polite tone, when talking to them.
- If they are rude, you can always ask "Is there anything about my behaviour that has made you feel you need to talk to me in this way?" (be sure you don't sound sarcastic, it will only make them more angry)

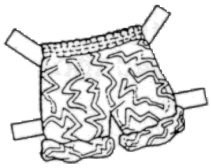
Give angry people choices

- Choices give them a feeling of control.
- Focus on what you are able to do, not what you can't do.
- Ask which solution feels best for them.

Remember...

- At Hamilton Health Sciences we see complaints as opportunities!
- We don't look to point fingers~ or lay blame, we look for ways to improve patient care.
- Patient Relations is there to help, call ext. 75240.

Walk out **those doors** wearing **hospital greens** and you're wearing **stolen property.**



Turn in your greens at the end of your shift and change into street clothes.

OUR PATIENTS AND YOUR CO-WORKERS ARE COUNTING ON YOU.