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Enough already Workplace violence

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The trouble with ‘resiliency’
It’s time to get to the root causes of healthcare worker burnout

By Irving Gold

Over the last several years, there has been an increasing recognition that burnout is rising exponentially among healthcare workers – and there has been a positive shift in the public understanding of burnout and other mental health issues in general. Unfortunately, the policy response from governments, healthcare institutions and policy-makers has been woefully inadequate.

Instead of addressing the root causes of burnout and mental distress among our healthcare workers, both before and as a result of COVID-19, what has been their response? A proliferation of toolkits and do-it-yourself resources developed and directed at healthcare workers that focus on helping them build their own personal resiliency.

On the surface, providing resources to healthcare workers to maintain or improve their mental health seems like a laudable goal. Who could argue against defining negative consequences.

Framing the issue of burnout as a lack of resilience is a classic example of victim-blaming. It places the causes, effects and solutions to the problem squarely in the hands of those suffering from it.

Let me be clear; there is absolutely nothing wrong with providing resiliency training or resources that focus on things like mindfulness, yoga, meditation, breathing exercises, visualization and the plethora of other solutions on offer. They can all be useful tools for addressing the crisis, and I am sure, many healthcare workers use and appreciate them.

But these are just band-aid solutions.

Resiliency toolkits and online resources do nothing to address the actual causes of healthcare worker burnout and mental health distress. The root causes are policy- and system-wide and not related to the shortcomings of healthcare workers themselves.

Among those I represent, Canada’s medical radiation technologists who administer radiation therapy to cancer patients, and do the X-rays, nuclear medicine, MRIs, and CT scans that allow doctors to diagnose and provide medical treatment, burnout is rampant.

Promoting personal resiliency is not a solution for inadequate staffing, unreasonable workload expectations, or insufficient leave. These are the issues that need to be addressed, and only governments, employers and leaders in the health sector can do it.

Healthcare decision-makers at the federal, provincial and institutional levels need to take this issue on in earnest. Those with power and access to the levers of change must stop hiding behind issues of jurisdiction and their singular focus on cost as justifications for inaction.

The pandemic has shown us that when governments face a national crisis, they can collaborate and surmount enormous challenges. Canada is emerging from the pandemic injured, but compared to other countries, we have fared fairly well. This is due, in large part, to the people that are the essence of our healthcare systems.

If we continue to turn the car radio up to drown out the sound of a malfunctioning engine, we will ultimately pay the price.

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UPCOMING DEADLINES

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A shortcut to immunity: Saving lives through early-stage COVID-19 treatment

By Arden Bagni-Fast

What images come to mind when you think about treating patients with COVID-19? Likely patients on ventilators, family members separated from loved ones, overwhelmed staff and overrun hospitals. It’s a disheartening picture, but what if we could avoid those experiences altogether by treating patients early in their disease progression? Good news: Healthcare providers at St. Joseph’s Healthcare Hamilton are doing just that in a new pilot program.

Dr. Zain Chagla, St. Joe’s Co-Medical Director of Infection Control, is leading a team that offers treatment for patients with early-stage COVID-19. It’s Ontario’s first dedicated clinic offering monoclonal antibody (MAB) therapy, and will help determine the feasibility of such a treatment center in other locations across the country.

UNVACCINATED INDIVIDUALS ARE BURDENING OUR HEALTHCARE SYSTEM, AND OTHER PATIENTS WHO NEED OUR HOSPITALS’ RESOURCES AREN’T ABLE TO ACCESS THEM

The therapy has been approved by the World Health Organization and the Ontario COVID-19 Science Advisory Table.

For now, Canada has access to this therapy delivered through a 30-minute intravenous infusion, but Dr. Chagla anticipates more products for early treatment of COVID-19 will be available in the future, including those that are available by intramuscular injection or oral capsules.

NO SUBSTITUTE FOR VACCINES

Dr. Chagla stresses that getting vaccinated is still the best line of defense. However, we have seen unprecedented levels of misinformation about the COVID vaccine, and various populations are skeptical of drastic government-mandated health policies due to historical mistreatment. Unvaccinated individuals are burdening our healthcare system, and other patients who need our hospitals’ resources aren’t able to access them: Across the country, surgeries are being delayed and healthcare workers are experiencing burnout. But Dr. Chagla sees this clinic as the start of a solution.

“We can save lives, and not just the patients who come into the clinic, but those who come to the hospital with other life-threatening circumstances. We are keeping those beds and resources available,” says Dr. Chagla. “It’s especially important now, as we enter one of the busiest times for hospitals (winter). If we can avoid being at critical capacity, that’s a win for everyone.”

WEIGHING SAFETY AND DUTY TO PATIENTS

Initial feedback about the clinic has been overwhelmingly positive. It has also raised important considerations about allocating resources to unvaccinated patients during a pandemic.

“First and foremost, healthcare providers have a duty to treat patients,” says Dr. Chagla. “Leaving your bias at the door – whether you’re treating someone who is vaccine-hesitant or not – is important. We do this in other forms of infectious disease. If someone with HIV didn’t take the preventive measures available to them, we wouldn’t deny them care. We are here to help patients and use the evidence-based tools accessible to care for them the best way we can. And in this case, we are saving lives.”

Arden Bagni-Fast is a Public Affairs Specialist at St. Joseph’s Healthcare Hamilton.

www.hospitalnews.com
William Osler Health System goes beyond for its people

By Catalina Guran

The last two years have taken a toll on the health care system and, most of all, on its people. Although health care workers are experienced and trained to be resilient, committed to their patients and dedicated to their profession, the COVID-19 pandemic has been challenging for everyone. Thankfully, ‘health care heroes’ continue to be there every day to care for their patients, and it’s often the little things that keep them going. That is why, in early 2021, William Osler Health System (Osler) implemented a Respite and Well-being Program designed to offer a wide array of services and supports for Osler teams, as they continue working around the clock to provide exceptional care to the community.

From outdoor yoga classes, mindfulness moments, and Employee Family Assistance Counselling, to Respite Rooms, ‘Compassion Carts’, virtual choirs and seated relaxation chair massages, Osler provides time and space for staff to momentarily escape some of the pressures.

There is a dedicated Respite Room at each of Osler’s three sites where staff can go for beverages, treats, wellness resources, or for some quiet time. Managers can also sign out Compassion Carts packed with snacks and drinks for short shifts to bring around to their teams. It’s small actions, like this, that have a big impact on teams. Staff at all levels are appreciative of the offerings but, Compassion Carts are the most popular element of Osler’s Respite and Well-being Program.

Staying hydrated and healthy isn’t always easy during busy shifts. The continued demands of the COVID-19 pandemic can leave staff feeling tired and Osler’s respite initiatives, play a vital role in helping staff stay Osler Strong.

“It’s not so much what we’re giving them,” explains Kiran Patel, Clinical Services Manager, Cardiac Diagnostics and Cardiac Rehab at Osler. “It’s that special moment to just say, ‘I’m thinking about you. I know today’s a really busy day and you probably haven’t had a chance to get to the respite room, so we’re going to bring it to you.’ It’s just knowing that they can pause for that moment to think about themselves.”

SUPPORTING MENTAL HEALTH WITH SCHWARTZ ROUNDS

Recently, Osler also implemented a new health and wellness initiative called Schwartz Rounds. One of the many ways Osler can put into practice its Values of Compassion and Excellence and help build healthy and resilient teams, Schwartz Rounds are a live, one-hour, interdisciplinary forum that aim to create open, honest and safe space where participants can candidly share their ideas, thoughts and feelings.

Due to the nature of their work, health care professionals often carry stress and emotional trauma, and the pandemic has compounded this. Osler team members who attend Schwartz Rounds gain greater insight into their feelings, grow their capacity for compassionate care, and increase empathy for individuals, patients, and their colleagues. Osler plans to hold Schwartz Rounds four times a year.

In line with its commitment to create resilient, empathetic teams and create a safe and healthy workplace environment, Osler leverages these many resources to provide emotional, physical and social support. Osler is proud to support its health care heroes always, to stay Osler Strong.

### Trans people accessing acute mental health care more likely to experience marginalization

Transgender individuals who access acute mental health care are more likely to experience marginalization, present with mood disorders and are twice more likely to be diagnosed with personality disorders than the general population accessing these services.

This according to a Centre for Addiction and Mental Health – (CAMH-) led study, “Characteristics of Transgender Individuals Accessing Emergency Department Visits and Hospitalizations for Mental Health,” newly published in the journal Psychiatric Services. The study is the first to use administrative health data to explore how transgender patients access mental healthcare services.

“It’s been theorized that trans people experience a disproportionately higher rate of mental illnesses, substance use disorders and suicidality, not because of their identity, but rather as a result of their experiences with discrimination, oppression and marginalization,” said lead author Dr. June Lam, a Staff Psychiatrist at CAMH. “This study provides further data to support this theory by looking at the experiences of trans individuals who required a mental health-related Emergency Department visit or hospitalization. Ultimately, the findings show an association between trans people who accessed acute mental health care and their experience with socioeconomic marginalization.”

The data collected for this study came from 728 transgender individuals who visited the Emergency Department and 454 transgender individuals hospitalized for mental health-related reasons, and who were aged 16 and above. The data originated from four
New equitable COVID-19 pandemic recovery in Canada

From income to housing to addressing racism and more, a new guideline proposes 13 ways to address inequities exposed and worsened by COVID-19 in the pandemic recovery period. The guidance is published in CMAJ (Canadian Medical Association Journal).

If not addressed, these inequities will continue to threaten the health of many Canadians.

“Coordinated pandemic responses include efforts to return life to ‘normal’ after the immediate threat, but the COVID-19 pandemic has underscored the need to address inequities rather than resume the unfair status quo,” writes Dr. Nav Persaud, a family physician at St. Michael’s Hospital, Unity Health Toronto, scientist and Canada Research Chair in Health Justice at MAP Centre for Urban Health Solutions, and associate professor, University of Toronto, with coauthors.

The authors define the pandemic recovery period as the stage when the direct harms of COVID-19 abate, but their recommendations may need to be in place for months, years or as permanent solutions.

Thirteen recommendations to address health inequities:

**INCOME**
- Ensure a living income
- Universal unemployment insurance, parental leave and paid sick leave
- Affordable loans

**HOUSING**
- Expand permanent supportive housing programs
- Expand access to eviction prevention, legal services and financial advice

**INTIMATE PARTNER VIOLENCE**
- Legal advocacy and supportive interventions for victims

**CHILDHOOD**
- Expand publicly funded childcare
- Healthy food distribution to children

The pandemic recovery period represents an opportunity to address health inequities that have led to an unfair distribution of the burden and harms of COVID-19. Policy changes at the federal, provincial and municipal levels that promote health equity had been studied before this pandemic, and they should be implemented before the next one,” the authors conclude.

“It is the societal and structural problems that abetted the spread of SARS-CoV-2 – not the pandemic’s economic effects – that have made COVID-19 such a devastating crisis. COVID-19 has taught us about the dangers of weaknesses in the fabric of society. Canada’s policy-makers would do well to follow Persaud and colleagues’ suggestion that postpandemic policy-making centre equity to ensure that all Canadians can benefit, and to protect against looming future threats,” writes Dr. Kirsten Patrick, interim editor-in-chief, CMAJ, in a related editorial.
Enough already: Workplace violence

By Henrietta Van hulle

The risk of violence is nothing new to Canada's healthcare workers. In my 17 years as a frontline nurse, I was hit, pinched, scratched and verbally abused. Thankfully these incidents never resulted in serious injury. But I know I was one of the lucky ones.

Throughout Canada's health care sector, violent incidents and acts of aggression continue to escalate in both frequency and severity. Healthcare workers describe violent events as daily occurrences, some so serious that they result in a range of physical or psychological issues, from chronic mental stress to anxiety, depression or post-traumatic stress disorder.

According to Ontario’s Workplace Safety and Insurance Board, assaults, violent acts and harassment in the province’s healthcare sector have steadily increased over the past several years, nearly doubling from 2012 to 2019. Workplace violence was the cause of 14 per cent of all lost-time injuries in 2019 in the healthcare sector – more than the injury claims allowed for exposures to harmful substances or environments. In 2020, while COVID-19 exposures accounted for the majority of lost-time injuries in Ontario’s healthcare sector, workplace violence remained among the top five injury types, with 993 cases.

As alarming as these figures are, it’s only the tip of the iceberg. The reality is likely more shocking as incidents of violence and aggression have been found to be severely underreported. Research indicates that this is most often associated with the normalization of violence among healthcare workers, and is attributed to the belief that violence is simply “part of the job”. Red tape, blame, lack of response from management and fear of reprisal are among other reasons.

The rise in incidents can be attributed to an aging population, increasing rates of dementia, a lack of access to mental health resources, overcrowding and wait times, and staffing shortages, just to name a few. Now, we add pandemic-related tensions to the list. Perhaps unsurprisingly, COVID-19 has exacerbated the situation. The pandemic has created an emotionally-charged environment ripe for aggression and violence, both in the hospital setting and out in the community. Some patients are prompted to commit aggressive acts out of fear for their health. Family members are responding to the loss of relatives, the inability to say goodbye or carry out funerals or other rituals as they’d like. Hospital workers are dealing with confrontations related to the enforcement of public health measures. Out in the community, healthcare workers have been stigmatized, harassed, threatened or assaulted for fear of spreading the virus.

Recent polling shows verbal, physical, sexual and racially directed violence against healthcare staff surging during the pandemic. A large provincial survey of hospital-based RPNs conducted by the Canadian Union of Public Employees (CUPE) and SEIU Healthcare found that 66 per cent of the more than 2,600 respondents said violence toward them or their coworkers from patients or patients’ family members has increased in the last 18 months. Hostility stemming from the pandemic is making an already stressful job that much more difficult. In the same poll, 87 per cent of RPNs said they have considered leaving their jobs.

If these behaviours are allowed to continue or worsen, the work environment and quality of care is certain to suffer. As feelings of anxiety and vulnerability deepen, workers may disengage, become less productive and feel less committed to their work, regardless of whether they are the target of the abuse. Failure to address inappropriate and unacceptable behaviours has financial consequences, too. Workplaces can experience increases in lost-time from work, workers compensation costs or health and medical expenses. Employers may also face charges, lawsuits or other legal action as a result of inaction and failure to protect workers.

Every worker should expect a safe and healthy work environment; violence should never be tolerated as part of the job. Hospital employers and management have a duty to protect employee health and safety and address unsafe working conditions, including includes taking action to prevent violent acts and threats of violence. Ontario’s Occupational Health and Safety Act (OHSA) requires employers to assess the risks of workplace violence and implement a policy and prevention program. Here are just a few examples of recommended program elements.

**CONDUCT REGULAR WORKPLACE VIOLENCE RISK ASSESSMENTS**

In Ontario, the OHSA states that employers must assess and control risks of workplace violence arising from the nature of the workplace,
type of work and conditions of work. Workplace violence risk assessments enable the healthcare organization to identify risks and prioritize action. This needs to be done as often as necessary to ensure that organizational policies and programs continue to protect workers. For these reasons, a workplace violence risk assessment should be completed at least annually, though each organization should have its own processes for determining how often to complete an assessment, and when to evaluate the effectiveness of the process. In light of the recent intimidation healthcare workers are facing just by going to work, this new risk should be assessed to ensure the workplace measures and procedures address this new threat.

**ENABLE A RISK COMMUNICATION OR FLAGGING-ALERT PROGRAM**

Employers in Ontario are required to provide all workers at risk with information (including personal information) about a person with a history or risk of violence. Workplaces, in turn, must adopt effective prevention strategies. One such strategy is a flagging-alert program to communicate violence-related risks to healthcare teams. By taking this kind of proactive approach to managing violent, aggressive and responsive behaviours, hospitals can reduce the risk of harm to workers while providing patients with the best possible care.

**ESTABLISH EMERGENCY RESPONSE PROCEDURES**

Ontario’s OHSA requires employers to develop and implement measures and procedures for workers to summon immediate assistance when workplace violence occurs or is likely to occur. One important measure is a formal emergency response procedure to workplace violence, also known as Code White. Code White is used in many healthcare settings to alert workers to a real or perceived threat of violence, which includes aggressive or responsive behaviours. Formal Code White procedures also ensure there is standardization and consistency in the response to workplace violence. Everyone in the workplace needs to be trained in the emergency response procedures and understand how to respond to workplace violence. Healthcare organizations are also encouraged to establish effective Personal Safety Response Systems that can effectively summon immediate assistance for impending workplace violence situations or incidents in progress. Recent protests at healthcare settings would indicate a review of current security practices.

**COMMUNICATE THE WORK REFUSAL PROCESS**

Workers in Ontario have the legal right to refuse work or refuse to do particular work that they believe endangers them, including situations of workplace violence. This legal right ensures that workers have a voice in situations of real or perceived danger. Employers, supervisors and Joint Health and Safety Committees (JHSC) need to define and support their organizational response to work refusals for reasons of workplace violence. Workers must also understand their right to refuse unsafe work as well as any related processes.

Of course, these are only a few of the actions hospital management and human resources departments can develop, implement and manage to control the risk of violence and prevent violent incidents. When developing a fulsome workplace violence prevention program, hospitals are encouraged to build off established leading practices for workplace violence prevention in healthcare.

An example comes from Public Services Health & Safety Association (PSHSA), an Ontario-based non-profit organization funded by the Ministry of Labour, Training and Skills Development to reduce workplace risks and prevent occupational injury and illness across the province’s public and broader public sector. PSHSA has released eight workplace violence prevention toolkits specifically designed for healthcare organizations to address the largest gaps in workplace violence prevention programs. Applicable to healthcare organizations of any size, the toolkits contain practical tools and resources for each of the aforementioned areas – risk assessment, flagging, emergency response, work refusals – and more to help healthcare organizations control the risk of workplace violence and protect workers.

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**If you’re an employer, we’re the only call you need to make.**
Keeping staff safe and secure for years to come

By Paul Baratta

In recent years, there has been an increase in the workplace violence rate in hospitals. Canada, the United States, and Australia have said that workplace violence is a pandemic in itself in healthcare, where clinicians, security and nursing are dealing with physical and verbal attacks more than ever before.

It’s, of course, no surprise with the current pandemic healthcare crisis, talent shortages, protesting and overall, an environment of heightened aggression. Hospitals and urgent care personnel are working around the clock treating COVID-19, managing patient backlog and soon, we will be amid that predicted autumn/winter surge with a looming flu season not far off.

As a result of this increased volatile atmosphere, hospitals and urgent care centres have been looking into modern technologies and asking how such can help provide quality care while minimizing in-person visits to decrease the possibility of exposure. Furthermore, there are questions on it that can be used to help better protect PPE equipment in temporary facilities, and provide additional safety, health, and security requirements for staff and even patients.

As we are witnessing, the impact of COVID-19 is not short-term. It’s driving the need for facilities to put into place long-term practices and adopt new technologies. Technologies that improve hospital and urgent care management today, but also address requirements for tomorrow.

ACCESS CONTROL ACTS AS A FORCE MULTIPLIER AND PUTS SECURITY IN FOCUS

Preventing the transmission of coronavirus in high traffic healthcare settings is without question, critical. Hospitals can get a handle on the virus by utilizing an access control system. This eliminates keypads thus reducing the number of shared access points. It can also be paired with a third-party system to automatically open and shut doors – further removing the need to touch any surface, such as a door handle.

The type of access control solution required, depends on a hospital’s needs. For small, basic installations, low touch access control that utilizes a QR code could do the work. It creates a credential with validity date and time. In this case, the employee receives the QR code, and from there, the network door controller receives their information and recognizes them. When they use the QR code, the system grants them access. Facilities can use a similar setup with RFID.

If there’s a need for more advanced security requirements, facilities can consider a more robust solution that encompasses an array of technologies not solely surveillance or security related. Such a system, takes advantage of the latest analytics and integrates seamlessly with other systems, such as intrusion detection, HVAC unit, HR systems, etc. Depending on the system, the network intercom or video door station, for example, could even play a pre-recorded announcement for the visitor to wear a mask before entering the building.

Hospitals can screen employees, visitors, and vendors upon entry by using a cross-line detection application, network surveillance camera, and a network horn speaker. When someone enters a predefined area, the solution automatically triggers an audio message.

Along with helping to mitigate the spread of viruses, access control solutions can help hospitals and urgent care centres better protect against unauthorized access, drug diversion, and protection of PPE and sensitive patient files.

Within hospitals and urgent care facilities, there are numerous locations that need to be well-secured. For example, restricted units with immune compromised patients, surgical units, or quarantined areas. An access control system helps by ensuring only authorized personnel enter these zones. If operations are looking to safeguard these quarters and mitigate the spread of infection, something like low touch access control is ideal.

Outside of a hospital setting, you can potentially have control over the system wherever you are with remote monitoring and communication. From any location, you can remotely open a door or speak to the person via your smartphone. A forced or propped open door can automatically trigger an alarm – this could improve business efficiencies as it reduces false alarms and makes managing staff easier.

THE ROLE OF WEARABLE SOLUTIONS

Wearable solutions have demonstrated they can decrease violent events in healthcare facilities. These devices have been employed in some healthcare facilities with audio solutions, by security and clinical staff to document events and situations.

If hospitals are looking to decrease violent instances, wearable solutions are quite effective at doing this. Consider a recent study by the National Health Services of Great Britain. It showed a reduction of violence towards nurses, other clinical staff, and users. It’s also moderating the way in which staff respond to patients. Some mental health wards in the UK have experienced a 28 percent reduction in workplace violence due to implementing body worn video solutions.

Nowadays, more people are brought to emergency rooms by law enforcement. They are evaluated for mental health reasons, and hospital security directors and clinical staff are reporting incidents of hostile behavioural events and an increase in physical and medical restraints. With body worn solutions, staff have reported a decrease in events, restraints, and other intervention due to both security and clinical staff announcing they are recording the event. The warning to people that they are being recorded, reduces the incidence of violence, and provides for documentation in case of the need for prosecution.

Other use cases for wearables in healthcare include documenting the movement of patients from hospital beds to specialized departments, such as for x-rays, and in behavioural health wards to document staff interaction with patients and their guests. Clinical staff may consider using these devices to document surgeries, facilitate training purposes, and in simulation rooms with student residence.

PRIVACY SHOULD BE AT THE FOREFRONT

One common theme to consider, and this applies to all surveillance solutions in hospitals and urgent care facilities, is around patient and visitor privacy.

Camera devices seem to be a concern regarding the expectation of privacy of patients, staff, and visitors given the sensitivities of the healthcare environment and the legal and regulatory circumstances they require.

A set of standards have been put into place to protect certain healthcare information, and this type of video footage qualifies as such: this law in Canada is instituted by the provinces as a Personal Health Information Privacy Legislation for the Health Sector.

Continued on page 13
Part of her support team.

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Emergency department tackles workplace violence with two new safety tools

By Robyn Cox

For physicians and staff in the Emergency Department (ED), physical and verbal abuse is a reality of the job.

A 2017 study of Ontario Council of Hospital Union members found 68 per cent of frontline staff said they had been physically assaulted in the past 12 months – with 86 per cent having experienced verbal violence in the same period. And more anecdotal reports and surveys suggest the pandemic has exacerbated the problem.

“Violence has always been present in our work, but I feel it has gotten progressively worse,” says Kerri, who works as a nurse in the ED at St. Michael’s Hospital of Unity Health Toronto and asked to be identified by her first name. “COVID-19 has increased people’s stress level. What we’re seeing now is that stress becoming overwhelming – and a visit to the ED is often the breaking point.”

A year ago, in the midst of wave two, the team in the St. Michael’s ED had reached a crossroads. “Between what we knew was statistically true about workplace violence in the ED and what we had anecdotally or personally experienced, there was a sense that enough was enough and we needed to take control of this situation and act on it,” says Justin Logan, a physician in the ED.

Logan and Kerri are members of the St. Michael’s ED Safety Committee, which brings together nurses, physicians, security personnel and other members of the ED team to improve safety in the department. Over the past year they and their colleagues on the committee have developed two safety initiatives: the Safety Dashboard and the Agitation Roadmap.

The Safety Dashboard is a digital tool that looks at the history of a patient and their real-time behavior to give healthcare providers an understanding of whether the patient has a mild-moderate or high risk of violence. The dashboard pulls from the hospital’s safety event reporting system and will identify if the patient was involved in violent incident in the past six months. Current behavior is measured using the Acute Care Violence Assessment Tool created by the Public Services Health & Safety Association (PSHSA) – which takes into account behaviours like confusion, paranoia and verbal or physical threats to provide an overall risk rating.

“The Safety Dashboard can be launched on the desktop of any ED team member to give them situational awareness of what’s happening in the department,” says Logan. “It’s updated every 15 minutes. If a patient’s violence assessment tool rating goes up or down during their time in the ED, it’s reflected on the dashboard.”

While the Safety Dashboard supports awareness on the team, the Agitation Roadmap empowers ED team members to take action based on that awareness. It provides specific steps to help manage difficult situations and suggestions to support patients who are agitated during their stay in the ED.

“I don’t think anyone who comes into the ED is having a good day,” says Kerri. “Sometimes it’s about acknowledging that everyone who comes through those doors is not at their best – and understanding that we can do little things that can make their day better.”

Suggestions on the Agitation Roadmap include asking team members, such as such as a community support worker, mental health nurse or physician, to check-in on a patient. The patient may be feeling agitated because they need food, water, warm clothing or pain management. A patient may also receive warnings from nursing or security to ensure they know that verbal abuse and violence won’t be tolerated. If agitation continues despite warnings, a physician will be notified to support timely decision-making on the patient’s care plan.

“These initiatives are about our people being safe so they can provide the best possible care,” says Kerri. “Our patients are the reason we are working – and that includes patients who are agitated. These tools help us to think about how we can approach the situation safely and compassionately.”

Both tools launched in November as part of the ED’s ‘No Violence November’ campaign for staff and physicians. The campaign included a blitz of awareness-building on how to use the new tools and an opportunity to facilitate honest conversations about the ED team’s experiences with violence.

“We’ve been having regular safety huddles – both morning and evening to cover both shifts. We’re giving staff an opportunity to ask questions. We’re explaining the Safety Dashboard and the Agitation Roadmap to encourage uptake,” says Logan. “It’s going to take a period of sustained communication and support to really engrain these initiatives into our regular protocols in the ED.”

Logan and Kerri are quick to note that improving safety in the ED is about long-term change and will take long-term strategies.

“This is only a starting point. It’s not a one-and-done situation,” says Kerri. “This is a culture change – and that takes time. Over the last year, I’ve witnessed my colleagues have a voice and make their concerns known. It’s extremely important because change can only happen through open communication and continual improvement.”

Robyn Cox is a Senior Communications Advisor at Unity Health Toronto
Keeping staff safe and secure

However, under law enforcement laws, hospitals will only disclose health information if required by law, under court order, warrant or subpoena to identify or locate a suspect, fugitive, witness, or missing person.

In response to law enforcement, officials will request information about a victim or suspected victim of a crime to alert law enforcement of a death. Hospitals are obliged by federal and local laws to inform police of any serious crime, the location of the victims, and perpetrator of a crime if they have the information.

SURVEILLANCE SOLUTIONS

Surveillance solutions installed today by hospitals and urgent care centres should not be a short-term fix unless it’s for a temporary facility. They should be adopted with the intention of them being a long-term answer that can help improve safety and quality of care today, as well as in many situations that could potentially occur in the future. Security and operations teams, need to ask themselves “Where do we start”? They should look to partner with a provider that will work with them by understanding their facility’s unique requirements. Network surveillance solutions should be integrated with other systems, and they should be adaptable, flexible and scalable.

Paul Baratta is the Segment Development Manager for healthcare for Axis Communications.

Workplace violence

The validated, consensus-based toolkits were built in partnership with stakeholders across Ontario’s healthcare sector and are available free of charge at www.workplace-violence.ca.

An evaluation of the initial five tools was completed to better understand their awareness, use and effectiveness among Ontario hospitals. Overall, 67 per cent of public hospitals in Ontario reported using at least one of the toolkits and, of these, 89 per cent reported improving their processes, programs and systems to prevent and manage workplace violence. Hospitals used the toolkits most often to identify safety risks, consider safety proactively in planning and validate or improve existing efforts.

While the risk of workplace violence is nothing new to Ontario’s healthcare workers, it’s been tolerated for too long. And now, as violent incidents continue to rise amid a growing fourth wave, where healthcare workers are already overwhelmed, burnt out and exhausted, they’ve hit a breaking point.

By building meaningful, cohesive and multi-faceted workplace violence prevention programs, Canadian hospitals can deliver results and sustainability in the prevention of violent incidents and protection of their employees. In turn, this will create a climate where workers feel comfortable coming forward with concerns and improves the ability to recruit and retain employees.

We know that healthcare workers play an integral role in our communities and are our healthcare system’s greatest asset. Ensuring a healthy healthcare workforce free from violence will help sustain quality care for all Canadians.

Henrietta Van hulle is Vice President, Client Outreach at Public Services Health & Safety Association. Henrietta began her career as a Registered Nurse where she cared for patients for 17 years before transitioning to occupational health and safety.
Test kits for staff result in ‘multiple saves’

Since the start of COVID-19, Windsor Regional Hospital (WRH) has learned that we need to review the science and research and be able to make changes quickly and safely for the protection of patients, staff and our communities. From adapting to changes involving personal protective equipment to clinical treatment of patients adapting to what we have learned over the last two years has saved lives of both patients and staff. In addition to adapting to changes we learned not one item in and of itself would protect our staff and community. We had to use a layered approach to protection from acquiring and/or spreading COVID-19.

Dr. Ian M. Mackay, a virologist at the University of Queensland, in Brisbane, Australia, created the “Swiss Cheese Respiratory Pandemic Defense”. Dr Mackay’s model made it clear not one single intervention is perfect at preventing spread of COVID-19. Others are shared responsibilities like vaccination, quarantine and isolation and border controls or stay at home orders. Two shared responsibilities that are also very important that sometimes are not focused on is fast and sensitive testing and appropriate air filtration and ventilation.

At WRH we have implemented a vaccine mandate for both staff and visitors with limited exceptions for visitors as a result of being an acute care facility with a trauma program. However, we have also recognized that vaccines do not have 100 per cent efficacy. Also, many of our staff are parents or guardians to children that were not or still not eligible for vaccinations.

While at home, parents are not wearing PPE with their children in their homes and as a result susceptible to acquiring COVID-19 and have limited symptoms as a result. This could result in a child returning to school and spreading COVID-19 to their class or the employee coming to work and doing the same to colleagues and patients. As a result, in August before school started we purchased rapid antigen test kits and provided them to staff for surveillance use at home. The fast testing referred to by Dr. Mackay. This has resulted in multiple “saves” to that has possibly avoided spread in our community, schools or hospital. WRH team members have shared their stories thanking the hospital team for making these rapid antigen test kits available to their family and avoiding even spread within their own household due to fast testing and “acting on the results”. Staff now use these test kits before they visit elderly loved ones or before they go to dinner with friends and family. Again, by itself the antigen test kits are not perfect at preventing spread. But added with other interventions it supports a defense to COVID-19.

Another intervention WRH added for its team members is carbon dioxide monitors (CO2). During earlier waves it became evident at many healthcare institutions across the world that staff rooms and areas in which staff took breaks to eat or drink resulted in spread of COVID-19 between staff. We looked at limiting the number of persons in each room at any given time as well as tried various dividers between staff with social distancing. However, air ventilation and filtration was not fully known. The addition of CO2 monitors in staff rooms allows for an objective measure of air ventilation that has been used by multiple countries across the world. The WRH staff are provided with written materials on the level of CO2 to be aware of that is safe versus the level that indicates air circulation and ventilation is not adequate and objectively determines that the conditions are more favourable for COVID-19 to be spread. At the end of the day you still need a positive COVID-19 person in the room however this objective measurement adds another layer to preventing the spread of COVID-19.

Similar to the Swiss Cheese model that will continue to expand as we proceed through this pandemic WRH will continue to actively monitor the science and research and implement changes that protect our patients, staff and community.
Disability claims – A primer

By Judith Hull & Katharine Creighton

As health care professionals, you are aware of the risk of becoming disabled at any age.

Prior to the pandemic, Canadian workers took an average of 8.5 days of leave for illness and disability in 2019.

The pandemic has had a significant impact on frontline health care workers’ mental health. A Statistics Canada survey, Mental health among health care workers in Canada during the COVID-19 pandemic, February 2021, revealed that 7 in 10 health care workers reported worsening mental health due to the pandemic.

For those who find themselves unable to continue working due to impaired mental health, chronic stress, or other health-related disabilities, it is important to understand which benefits may be available to you.

Workplace Safety and Insurance Benefits (WSIB) are available to many hospital workers, provided that the illness or impairment is sustained by accident, arising out of and in the course of one’s employment. Critically, amendments to the Workplace Safety and Insurance Act in 2017 now permit chronic or traumatic mental stress arising out of and within the course of the worker’s employment to be insurable. A diagnosis of post-traumatic stress can also qualify certain enumerated workers for benefits, provided certain conditions are met.

If your employer does not offer a short-term disability plan, or you do not qualify for the benefit, you can apply for Employment Insurance (EI) sickness benefits. EI benefits can provide you with up to 15 weeks of financial assistance if you cannot work for medical reasons. You could receive 55 percent of your earnings up to a maximum of $595 a week.

Long-term disability benefits are often available either through a group plan (such as your employer or union, college or professional affiliations) or can be purchased privately. Often, group plans provide basic coverage. For high-income earners, it is wise to purchase additional long-term disability coverage privately. If you pay the entire amount of the disability premium yourself (e.g. by funding your own private insurance, or as a source deduction from your paycheque), your disability benefits will be tax-free. If your employer pays all or part of the disability premium, your disability benefits will be subject to deductions for income tax.

Again, each disability plan is different so you should review your policy to see what you might be entitled to should the need arise.

Another source of benefits is the Canada Pension Plan Disability (CPPD) benefits. They are intended to provide partial income replacement to eligible CPP contributors who are under age 65 with a severe and prolonged disability, as defined in the Canada Pension Plan legislation. There are two eligibility criteria for the CPPD program:

- Applicants must have made contributions to the program in 4 of the last 6 years, with minimum levels of earnings in each of these years, or 3 of the last 6 years for those with 25 or more years of contributions; and
- They must demonstrate that their physical or mental disability prevents them from working regularly at any job that is substantially gainful, and that it is long-term and of indefinite duration or is likely to result in death.

Not all disabilities can be plainly seen or are easily recognized. The benefits outlined above are intended to safeguard you from an unexpected disability, including impaired mental health and chronic stress, that effects your ability to work and earn an income.

Judith Hull and Katharine Creighton are lawyers with the Personal Injury Team at McKenzie Lake Lawyers LLP.

www.mckenzielake.com

www.hospitalnews.com
Hypnotics, sedatives, and non-pharmacological strategies for the management of insomnia

By Rami Al Khouri, Vikrant Raina, and Certina Ho

Carol, a 34-year-old schoolteacher, visits her local pharmacy with a one-month prescription for Temazepam 15 mg at bedtime. Carol has trouble falling asleep and feels fatigued during the day. The pharmacist noticed that she picked up a prescription for Zopiclone 5 mg at bedtime two weeks ago. Carol explains that she has been using Zopiclone for over a year but feels it has stopped working. She has not tried any other treatment options.

WHAT IS INSOMNIA?

Carol has insomnia, a condition characterized by having difficulty falling asleep, maintaining sleep, or being unable to return to sleep upon early morning awakening, occurring at least three nights per week for at least three months without being substance related. Prescription medications approved for the treatment of insomnia include benzodiazepines (e.g., Temazepam) and benzodiazepine receptor agonists (Z-drugs) (e.g., Zopiclone). Benzodiazepines and Z-drugs are often found in the list of the top 50 drug products prescribed in Canada.

BENZODIAZEPINES

Benzodiazepines are prescription sedative-hypnotic medications typically used to manage insomnia, anxiety, seizure disorders, or to help relieve muscle spasms. They are also associated with side effects (e.g., dizziness, drowsiness, and fatigue, etc.). Benzodiazepines are beneficial in managing insomnia only if used intermittently and for a short duration (e.g., two to four weeks). Long-term use of benzodiazepines for sleep may lead to tolerance, meaning that more medications are needed to achieve the same effect over time. Using more benzodiazepines may also put the patient at risk of dependence. When a patient abruptly stops taking benzodiazepines or takes a lower than usual dose, withdrawal symptoms such as anxiety, insomnia, gastrointestinal upset, hand tremor, increased heart rate, or other more severe symptoms (e.g., confusion, hallucinations, seizures, etc.) may appear one to two days after discontinuation. Therefore, benzodiazepine use should be individualized, closely monitored, and regularly evaluated; dose tapering should be done gradually with regular follow-up and monitoring.

Z-DRUGS

Z-drugs (e.g., Zopiclone) are prescription medications indicated for the management of insomnia in the short term (e.g., two to four weeks) and have similar therapeutic effects on sleep but fewer adverse effects than benzodiazepines. Side effects may include metallic taste, dry mouth, dizziness, daytime sedation and somnolence. There is potentially increased risk of falls in older adults with the use of Z-drugs, and caution is advised for its use. Long-term use may cause tolerance and dependence, leading to withdrawal and rebound insomnia.

SAFETY ADVISORY

In October 2020, Health Canada issued a public advisory on updated safety labelling for benzodiazepines and Z-drugs where the following potential risks are alerted to healthcare professionals and patients:

• Problematic use of these medications and/or substance use disorder may lead to overdose or death, particularly when combined with other medications.
• Abrupt discontinuation or rapid dose reduction of these medications may cause severe withdrawal symptoms and pose life-threatening risks.

• Harm when taking these medications with opioids, which may cause deep drowsiness, respiratory depression, coma, and/or death.
• Falls and fractures in special populations (e.g., older adults).

HEALTHCARE PROFESSIONALS SHOULD COLLABORATE AND PROMOTE SAFE MEDICATION USE AND EFFECTIVE MANAGEMENT OF INSOMNIA.

The American Academy of Sleep Medicine (AASM) published a Clinical Practice Guideline for the Pharmacologic Treatment of Chronic Insomnia in Adults in 2017 and a Clinical Practice Guideline for Behavioral and Psychological Treatments for Chronic Insomnia Disorder in Adults in 2021. Although pharmacological agents play a role in managing insomnia, both benzodiazepines and Z-drugs are recommended to be used for short term. With or without pharmacological agents, behavioural and psychological treatments are found to be highly efficacious for the management of chronic insomnia in adults. Clinicians should consider the use of multi-component cognitive behavioral therapy for insomnia (CBT-I), which includes sleep restriction therapy, stimulus control therapy, cognitive therapy, and relaxation techniques. CBT-I is usually provided to patients once weekly for four to eight weeks by a clinician trained in behavioural sleep medicine. Further information on CBT-I, with or without pharmacological agents, is available at a resource prepared by the Toward Optimized Practice (TOP) Insomnia Group in Alberta. Top Ten Sleep Tips for Patient Self-Management and other resources are also available at the Accelerating Change Transformation Team (ACTT) Assessment to Management of Adult Insomnia (https://actt.albertadoctors.org/CPGs/Pages/Adult-Insomnia.aspx).

ROLE OF INTERPROFESSIONAL COLLABORATION

Healthcare professionals should collaborate and promote safe medication use and effective management of insomnia. For example:

• Prescribers should consider the lowest effective dose for the shortest appropriate duration.
• Pharmacists should communicate with patients on the appropriate use of sleep medications in the short term, emphasize the importance of behavioural and psychological treatment options (such as CBT-I), educate patients on potential drug-drug interactions and side effects of medications.
• Patients can use the “5 Questions to Ask About Your Medications” (https://www.ismp-canada.org/drec/5questions.htm) to initiate a dialogue with their healthcare provider(s) to learn more about their medications, behavioural and psychological treatment options for management of insomnia.

WHAT CAN WE DO FOR CAROL?

Due to Carol’s prolonged use of Zopiclone, she is at an increased risk of developing tolerance and dependence. Carol would likely benefit from exploring non-pharmacological options like CBT-I, with or without pharmacological agents. If Carol is to taper/discontinue Zopiclone and start a new therapeutic agent (e.g., a benzodiazepine), it should be prescribed at the lowest effective dose for the shortest possible duration, with follow-up, monitoring, and regular communication between Carol and her healthcare provider(s).

Rami Al Khouri and Vikrant Raina are PharmD Students at the Leslie Dan Faculty of Pharmacy, University of Toronto; and Certina Ho is an Assistant Professor at the Department of Psychiatry and Leslie Dan Faculty of Pharmacy, University of Toronto.
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JANUARY 2022 HOSPITAL NEWS 17
Surgeons from Hamilton Health Sciences’ (HHS) two largest hospitals are travelling to Grimsby on a regular basis, bringing their specialized surgical skills and expertise to patients at West Lincoln Memorial Hospital (WLMH).

The 10 surgeons from the Juravinski Hospital and Cancer Centre (JHCC) and Hamilton General Hospital (HGH) are part of WLMH’s Surgeon of the Week (SOTW) program, where they take turns working one-week stretches in Grimsby.

The program started in 2020, along with upgrades to the hospital’s ORs and endoscopy suite that year and the introduction of a first-of-its-kind program to recruit and retain OR nurses.

All SOTW physicians are general surgeons, trained to provide a wide range of surgeries. Several also specialize in areas including liver, pancreatic, colorectal and breast surgery. All three hospital sites are part of HHS.

“The SOTW program means that patients from West Niagara can receive high-quality surgical care close to home,” says Dr. Ved Tandan, WLMH’s site chief of surgery. Tandan, a general surgeon specializing in liver and pancreatic surgery, developed the program and recruited the physicians. He also participates in the weekly rotations.

“It’s a real win-win for the WLMH operating room team and community residents to have specialized care available close to home,” says Angela Leslie, clinical manager of colposcopy, obstetrics and peri-op services at WLMH, and nurse manager for the SOTW program.

Joining Tandan from the JHCC are Dr. Stephen Kelly, surgeon in chief for HHS; Dr. Shawn Forbes, JHCC’s site chief of surgery; and Dr. Deepak Dath and Dr. Elena Parvez. The HGH physicians are Dr. Samir Faidi, medical director of the trauma program; Dr. Niv Sne, head of general surgery at HGH; and Dr. Kamya Khamamoui, Dr. Edward Passos and Dr. Tim Rice.

Through the SOTW program, these surgeons provide general surgery services at WLMH. This includes consultations for patients in the emergency department, and inpatient and outpatient referrals. Procedures include day surgeries, endoscopy procedures and follow-up care.

“We’re not just there to operate,” says Tandan. “Our surgeons provide the full scope of care for patients.”

With this model of care, surgeons spend one-week stretches at WLMH where they’re developing strong professional relationships with the staff, patients and the community. “They’re not just parachuting in to do a surgery and then returning to the city,” says Tandan.

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For example, patients with specific health care issues, such as those needing liver or pancreatic surgery, can be referred to the general surgeon specializing in that field. If they need a larger surgery, they may be referred to a Hamilton hospital, but could receive before-and-after care at WLMH.

Fourth-year McMaster University life sciences student Harriet Owen is doing a placement at WLMH, and is researching other similar programs.

“I’ve done some research into this type of program and it’s fairly unique, especially in Canada,” says Owen. “I think it’s more common in Europe, especially England and Northern Ireland.”

Finding surgeons to participate in SOTW wasn’t difficult. In fact, more JHCC and HGH surgeons offered to take part than were needed. That interest could come in handy when the new Grimsby hospital is built. The existing two updated operating suites will be replaced by three brand new operating suites and a procedure suite for endoscopy and minor procedures.

“It won’t be a challenge to find surgeons willing to travel to West Lincoln, that’s for sure,” says Tandan. “Everyone loves coming here. It’s a terrific hospital with excellent facilities and a friendly, welcoming and talented operating room team.”

WLMH Surgeon of the Week team members and supporters include Dr. Elena Parvez, Dr. Thomas Suhadolc, Dr. Ved Tandan, Dr. Joan Bellaire, Angela Leslie and Cindy MacDonald.

Prior to the SOTW program, WLMH had one full-time general surgeon dedicated to the full scope of general surgery. This new SOTW approach – developed after that surgeon retired – features a rotating team of JHCC and HGH surgeons. The SOTW approach means that West Niagara patients benefit from a wide range of subspecialty expertise.

APPRECIATED BY PATIENTS

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Giving frontline workers more flexibility to prevent burnout

By Peter Faist

As bleak as they are, the increasingly frequent headlines about health care workers getting burned out by the COVID-19 pandemic should come as no surprise.

The conditions for burnout have always been prevalent in health care, particularly in hospital settings. Working on the front lines in a hospital in any role – whether as a nurse or physician, or as a personal support worker or technician – can be physically, mentally and emotionally draining. There are long hours, high levels of stress, a complex work environment to navigate and the heavy emotional toll that comes from caring for patients who are often in desperate need of help.

Add the increased demand created by a global pandemic and a chronic shortage of health human resources to the mix, and it’s easy to understand why burnout has increased dramatically over the past two years and hundreds of health care workers have decided to leave hospitals for jobs elsewhere.

Research released in October by Ontario’s Science Advisory Table on COVID-19 found more than 60 per cent of Canadian physicians, nurses and other health care workers reported they were experiencing severe burnout – a significant increase over the pre-pandemic prevalence rate of 20 to 40 per cent. Over the same time frame, vacancies for frontline positions in hospitals and other health care settings have risen to record levels, according to Statistics Canada.

To avert a vicious cycle where understaffing leads to increased burnout and an even weaker health care workforce, the science table recommends interventions to reduce burnout need to be implemented at organizational and structural level of health care systems, including visible and authentic senior leadership and managerial support, training to increase worker confidence with unfamiliar tasks, supporting workers experiencing moral distress and addressing work load to reduce overtime and shifts that stretch longer than 12 hours.

Government initiatives to help address staffing shortages, enhance training, and increase compensation for key positions like personal support workers have helped to temporarily alleviate some of the staffing pressures.

But we need to examine creative solutions to alleviate some of the systemic issues and working conditions that have been causing burnout in hospitals long before the pandemic took hold nearly two years ago.

Introducing more flexibility in scheduling is one obvious area where hospitals can look to the outside business world for guidance on how to make working conditions more appealing and to help recruit and retain staff.

Allowing workers to set their own hours and work off-site was already beginning to be tested by some progressive companies prior to COVID-19, but many organizations embraced flexible shift models out of necessity when the pandemic forced them to adapt. In many cases, they’ve found employee productivity and job satisfaction have increased with less-rigid scheduling.

Hospitals don’t have the same options to let frontline health workers do their jobs from home, but we need to explore innovative new ideas to provide more flexibility in scheduling and help hospitals optimize their workforces.

Continued on page 22
A creative reprieve for healthcare workers

As the pandemic continues, the Hamilton community has been showing their gratitude to healthcare workers any way they can. This includes Dundas Valley School of Art (DVSA). Understanding the therapeutic benefits of art, DVSA took it upon themselves to create the Art to Heart program, a series of free art classes for healthcare workers.

“DVSA already has many healthcare workers among our students, and we knew, pre-pandemic, they appreciated the time in the studios,” says Claire Loughheed, DVSA executive director. “In undertaking the Art to Heart program, we felt we could offer healthcare workers a positive outlet. Self-care is more critical than ever for healthcare workers during these times.”

ART THERAPY FOR HEALTHCARE WORKERS

The program began in March and offered eight classes over eight weeks with a different project each class. All activities were specifically designed for people without an artistic background. Materials were provided in advance, for free, and classes were offered online. Classes were led by a certified art psychotherapist as they were intended to provide a greater therapeutic element then a simple “how to” class.

Funded by the Hamilton Community Foundation, 58 healthcare workers from across Hamilton participated in the program. With a long waitlist and favourable feedback, DVSA hopes to be able to offer the program again soon.

FEELING REJUVENATED

“It was such a positive experience,” says Suganya Vadivelu, education and development clinician at Hamilton Health Sciences. “There was a lot of self-reflection and looking into deeper meanings of the art we created. I really enjoyed it and felt rejuvenated after each class.”

In the past, Vadivelu had taken art classes recreationally. So when these classes became available, she knew it would be something she’d enjoy. She even had her two sons participate with her.

“Not only were the classes a great break from daily stresses, but it gave me the opportunity to spend time with my kids,” she says. “My older son and I had so much fun in the scribbles class. It wasn’t just scribbling on a page, we actually reflected on what we saw and how it made us feel, then developed the drawing further. We turned scribbles into art!”

SPECIAL FAMILY TIME

They enjoyed the classes so much that Vadivelu, her husband and their kids now have a family art night once a week. Despite the family seeing each other more often due to the pandemic, she says their family art night is a special way to spend time together.

Vadivelu is proud of the pieces of art she created during the Art to Heart program and keeps them in her office at the Juravinski Hospital and Cancer Centre. She finds they give her a moment of reprieve throughout her day, and she smiles when reminiscing on the quality time with her family.

“For those working in the hospital during a global pandemic, those moments can make a world of difference. “From the bottom of my heart, thank you to Dundas Valley School of Art,” says Vadivelu.
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What and why now?

Health leader and leadership development priorities in 2022

By Jaason Geerts

The landscape of leadership development is resettling after the seismic shift that began in the early months of 2020. During the pandemic, most formal development programs have been canceled or postponed, in favour of crisis response and recovery. Two years of real-time, on-the-job, in completely unfamiliar circumstances, trial-by-fire also present an enormous opportunity to consolidate leadership development and advance systems transformation.

**TRENDS IN LEADER AND LEADERSHIP DEVELOPMENT**

The Canadian College of Health Leaders (CCHL) has observed several consistent trends thus far during the pandemic.

**Individual leader development**

Demand for support and development from individual leaders has spiked, especially given the general hiatus on formal leadership initiatives. Desired programming has included:

- micro-learning on targeted and timely topics – what tools will help me with my patients or staff tomorrow?
- our Community for Practice (called The Circle) that people can access at their convenience and engage with others
- peer discussion formats in a psychologically safe space where participants can share experiences cathartically, be vulnerable confidentially, find reassurance that other intelligent, competent leaders are also having difficulties, and exchange examples of what appears to be working at their institution (best practices). Many executives have gravitated to this format, grateful to connect with colleagues facing similar pressures
- executive coaching and mentors on demand, particularly external to the organization
- earning the Certified Health Executive (CHE) credential, which validates the importance of leadership and value of evidence-based development.

**Leadership development across departments and organizations**

Although much has been on hold, some organizations have managed to introduce the following programs:

- structured forums with senior or executive teams (SLT/ELT) to devise a leadership plan to achieve strategic priorities, especially in light of the shifted organizational context
- formally debriefing pandemic lessons among leaders and staff at all levels to contribute to service and system improvements, increase staff engagement, and decrease turnover and absenteeism
- think tanks featuring a brief presentation, followed by small group discussions and full group summaries.

**Topics include leadership learnings, health HR, burnout, pandemic lessons, and innovation**

- 360 assessments and aggregate reports that provide individuals and organizations with a snapshot of key strengths, areas for improvement, and the dispersion across levels of leadership for the sake of self-awareness, succession planning, and leadership development
- building internal capacity by training and licensing those who can develop and lead programs internally.

**HR/OD THINK TANK**

The remainder of this article is informed by a recent Think Tank hosted by CCHL for healthcare HR/OD professionals across Canada. Participants were asked, “What training, development, or support do leaders in your organization need most in the next 6 months?”

The two priority populations mentioned were executives and new managers, 360’s and succession planning were cited as priorities for executives.

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**Prevent burnout**

The rising popularity of digital platforms that allow personal support workers, nurses and other health workers to pick up shifts on an occasional basis at hospitals and other health settings shows that there’s a strong appetite among trained health care workers to have greater control over when, where and how they work.

Insufficient supply isn’t fully to blame for our worsening health human resources problem. Despite widespread shortages of labour in some positions, there is a large pool of highly qualified health-care workers in the broader workforce who are trained, available and willing to help on a casual or temporary basis. Others appreciate the flexibility of gaining relevant experience in different settings a couple of days per week as they study to become the next generation of nurses and doctors, or simultaneously managing other responsibilities like parenting and caregiving.

Our hospitals and health-care system can’t afford to lose more personnel to burnout. We need to take advantage of every tool and examine every solution that allows us to use our existing human resources more effectively to prioritize frontline and patient care. 

Peter Faist is CEO of Toronto-based Staffy, a digital platform that connects health care employers with qualified, pre-vetted staff to fill vacancies on a temporary basis.
Professional Development and Education

Topics for new managers included business acumen, emotional intelligence, leading remote teams, navigating change, and establishing a just culture.

**Keys to Success**

To develop leadership capacity, the key success factors that emerged were:

- Outcomes-based (i.e., expectations of tangible results)
- Relevant (that it’s clear to participants why now)
- Contextualized and personalized
- Multi-modal, varied, and flexible

**Leadership Development Priorities for 2022**

With an eye to 2022, five leadership development priorities should be on every VP people’s radar.

1. **Emergency preparedness, strategic foresight, and adaptability**
   
   It is vital that organizations ensure that they have capacity and training to manage future pandemic waves and crises. To maximize the learning, preparing for emergencies should include anticipating future trends and opportunities through strategic foresight exercises and a focus on becoming a highly adaptable organization.

2. **Promoting and training diverse leaders to advance strategic priorities in the endemic context**
   
   Leader turnover has been seemingly incessant and much more is expected shortly, which is an opportunity to select replacements who have the capabilities and potential to lead in and beyond the endemic context. HR and executives should actively pursue ideal candidates with a priority on diversity.

3. **Increasing the efficiency of high-quality care using available resources**
   
   The urgency of the pandemic response has forced creative innovations, collaborations, and ways of leading. Now, as we face the massive service backlog with a depleted workforce, it is critical to discuss how to optimize efficiency without sacrificing quality or staff wellbeing. This involves ‘getting to no’ – making hard decisions about what should be cut or managed elsewhere to devote most attention to the vital imperatives.

4. **Prioritize diversity**
   
   Talent management, including succession planning and training, should prioritize qualified diverse candidates in terms of selection committee participation and development program participants and faculty.

5. **Develop the culture of a leadership organization**
   
   A “leadership organization” elevates the concept of a learning organization exponentially by respectfully enabling staff at all levels. It involves embedding the importance of leadership into the organizational DNA and integrating common leadership language in all HR/OD functions: job descriptions, selection criteria, performance evaluations, etc.

   These organizations aren’t handcuffed by stagnation or excessive bureaucracy, nor are they haunted by the ghosts of brilliant ideas that never had a chance to find flight. All staff are encouraged to innovate at their discretion without requesting permission, in alignment with organizational values and priorities. Outcome data are measured transparently and some failures are expected, but staff are accountable to the overall, not the every time. The result of this culture? Continuous and quantum improvement is a natural expectation and consequence organization-wide.

**Conclusion**

The defining question for health leadership in 2022 is whether systems want to operate or optimize? (The latter includes performing surgical procedures). This deplorable trial-by-fire for leaders has generated incredible lessons that are available on request, which, if actioned and resourced, could improve our work and healthcare provision, as well as igniting transformations and culture shifts to become leadership organizations. This is the way forward.

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Dr. Jaason Geerts, PhD, is Director of Research and Leadership Development at the Canadian College of Health Leaders.

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New study finds professional workers report significantly higher rates of mental health distress during the pandemic

Preliminary findings from a new study that focuses on the gendered nature of mental health issues, leaves of absence and return to work experiences from a wide range of professions has found that mental health declined and distress, presenteeism and burnout increased significantly during the COVID-19 pandemic for all workers studied, but particularly for women and in the professions where women dominate.

Mental health during the pandemic declined notably for workers in nursing, midwifery, and teaching professions, where women significantly outnumber men, the study has found. The decline in mental health was also significantly greater for women physicians than their male colleagues.

The study also found the compound effect of declining mental health and increased distress, presenteeism, and burnout is linked to a rise in intention to leave either the organization or the profession entirely, particularly in the female-dominated nursing and midwifery professions.

Thirty-nine per cent of nurses thought about leaving their healthcare facility and 31 per cent their profession, while 34 per cent of midwives thought about leaving the profession.

The Healthy Professional Worker Partnership study is a cross-Canada collaboration under the direction of Dr. Ivy Bourgeault, Professor in the School of Sociological and Anthropological Studies at the University of Ottawa, and in partnership with relevant industry- and professional organizations. The on-going study is examining the cumulative effects of declining mental health, distress, and increased burnout are leading a significant proportion of nurses to consider leaving their jobs or nursing altogether.

The study found that all professions experienced increased work stress during the pandemic, including increased workload, digital stress; feelings of being left out of decision-making; physical safety and ethical dilemmas (nursing) and the stress of running a practice and uncertainty (dentistry).

All professions also experienced increased non-work stress, such as time pressure, underlying mental and physical health conditions, caring for children, family safety (nursing) and debt/financial concerns (dentistry).

“The Healthy Professional Workers report shows the negative impact the pandemic has had on the female-dominated nursing profession,” says Linda Silas, President of the Canadian Federation of Nurses Unions.

“The cumulative effects of declining mental health, distress, and increased burnout are leading a significant proportion of nurses to consider leaving their jobs or nursing altogether. Governments must address the long-term mental health impacts of the pandemic and challenge the systemic sexism that normalizes nurses’ poor working conditions, in order to stem the exodus of nurses from the profession,” Silas says.

“In our gendered profession, midwives experience compounded stress and mental health deterioration, especially since the pandemic,” says Lehe Spiegelman, President of the Midwives Association of BC.

“Preliminary findings of this study reveal that these key issues our profession faces including extreme stress, burnout and lack of pay equity, contribute to midwives planning to leave the profession. It is imperative that we wholeheartedly commit to building adequate infrastructure that supports health and wellness for all professions and the stability of healthcare systems,” she adds.

“I witness the findings of this report every day in my work,” says Jasmin Tecson, President of the Association of Ontario Midwives. “For midwives, like so many other healthcare providers, COVID-19 has placed an additional burden on us in an already stretched system. We need action to ensure we centre the wellbeing of health providers. Without this, the health system is in peril,” Tecson adds.

“We were struggling with high levels of burnout and other mental health challenges prior to the COVID-19 pandemic due to increasing workload and a critical shortage of human resources, among other factors,” says Dr. Katharine Smart, President of the Canadian Medical Association.

“The pandemic has exacerbated those challenges to unprecedented levels and created many new issues, leading some healthcare workers to leave their professions entirely.

There are no short-term solutions to this complex issue – it will take years to build a robust healthcare workforce across the country to address gaps and reduce long waits for health services. We need to prioritize health human resource planning now so we can ease the burden on healthcare workers and provide more timely access to care for Canadians,” she says.

BACKGROUND

Every year one in five people in Canada experiences a mental health (MH) issue, with an estimated cost to the economy of more than $50 billion.

In the workplace, MH-related leaves account for approximately 30 per cent of short- and long-term disability claims, yet many women and men in their peak working years suffer in silence, continuing to work despite experiencing significant MH issues (presenteeism).

Only one in three people who experience a MH problem report that they have sought treatment or services. Forty per cent of workers found employers were not accommodating of their MH issues. The combined effects of absenteeism and presenteeism due to MH issues are estimated to cost more than $6 billion in lost productivity.
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Clinical externs program supports patients and strengthens learning

In January 2021, Ontario Ministry of Health announced a new clinical extern program to provide support to organizations with health human resource challenges resulting from the pandemic. Select hospitals in Ontario, including Hamilton Health Sciences (HHS), were invited to participate.

Currently, HHS employs 200 clinical externs (from nursing, respiratory therapy, and paramedic academic programs) as part-time unregulated health care workers. The externs work in different clinical areas across HHS including medicine, surgery, pediatric, emergency, and critical care.

The program is scheduled to end March 31, 2022.

DIRECT BENEFITS TO HHS
Clinical externs are supernumerary unregulated health care workers who help with several care tasks such as assisting patients with activities of daily living, supporting positive patient experiences (such as supporting ambulation, positioning, feeding, and toileting) as well as supporting admission assessments and tasks.

“Assistance with these activities alleviates nurses of basic care tasks and allows them to focus on specific responsibilities that cannot be delegated,” says Charissa Cordon, Chief of Nursing Practice at HHS. “Students participating in this initiative will be learning very important clinical skills, and the program will help students transition into the professional roles much easier, making them job ready at graduation.”

The program is supported by clinical extern coordinators who are experienced regulated health care professionals who provide support and mentorship to the clinical externs and their leaders.

There are direct benefits for HHS according to Kirsten Krull, VP Quality and Performance and Chief Nursing Executive. “These future nurses are augmenting their breadth of practical experiences and building confidence in patient and family care, and concurrently gaining experiences of belonging to and learning first-hand about inter-professional team work,” she says.

Participating in this program will also enhance patient experiences by supplementing healthcare worker supports at the bedside during this time of heavier workloads.

A PATHWAY TO HIRING
Over the past year, in a time of significant health care worker shortages, the clinical extern program has provided HHS with access to previously untapped clinical learners. It has provided a pathway to hiring with a centralized hiring process to support this. Externs experience more of what HHS has to offer, influencing their visions for nursing jobs upon graduation.

The majority of clinical externs working at HHS are nursing students. To date, 82 per cent of graduating nursing students working as externs have been recruited and transitioned into nursing positions at HHS.

“I have felt welcomed from the first day I started, and the nurses constantly mention how appreciative they are to work with the externs.”
PROFESSIONAL DEVELOPMENT AND EDUCATION

“STUDENTS PARTICIPATING IN THIS INITIATIVE WILL BE LEARNING VERY IMPORTANT CLINICAL SKILLS, AND THE PROGRAM WILL HELP STUDENTS TRANSITION INTO THE PROFESSIONAL ROLES MUCH EASIER, MAKING THEM JOB READY AT GRADUATION.”

get the extra helping hand,” says Jessica Loiseau, a former extern who is now working as a registered nurse at HHS.

A “WONDERFUL OPPORTUNITY”

“We thank the Ontario Ministry of Health for this wonderful opportunity for HHS to participate in this well thought out and yet flexible program that we can design to best meet our needs,” says Rebecca Fleck, Director of the Regional Rehabilitation Program at HHS. “And it wouldn’t be possible without our partners. It is a mutually beneficial program for all involved.”

HHS is pleased to work with academic and community partners – namely, McMaster University, Mohawk College and Conestoga College – to implement this program.

“Partnering with HHS in this extern initiative provides an opportunity to strengthen the future of learners in our BScN Program (McMaster-Mohawk-Conestoga). It is important for us to contribute to quality patient care,” says Joanna Pierazzo, Assistant Dean, Undergraduate Nursing Programs, McMaster University. “We look forward to our learners having an opportunity to mentor alongside other nurses.”

The clinical extern position is viewed as a developmental role, whereby students develop clinical expertise, specialty knowledge and self-confidence as they move from a student to a regulated health care professional role. Externs have unregulated care provider status and are supervised by a regulated health care professional during their time at HHS.

“Students participating in this initiative will be learning very important clinical skills, and the program will help students transition into the professional roles much easier, making them job ready at graduation.”

Jessica Loiseau, was an extern and is now working as a registered nurse at HHS.

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Moral distress – a challenging experience

By Caitlin Renneson

As a hospital screener during visitor restrictions, you must say no when a woman asks to visit her husband of 30 years. Your supervisor pressures you to order what you consider to be unnecessary tests for a patient.

When you feel that circumstances beyond your control are affecting the safety or integrity of your work, you might be experiencing moral distress.

Three experts from The Ottawa Hospital provide insight into how to identify moral distress – and what to do if it happens to you.

WHAT IS MORAL DISTRESS?

Moral distress can occur in the workplace when you feel that circumstances beyond your control are affecting the safety or integrity of your work. This is important because our feeling of moral integrity is fundamental to our experience of moral meaning as health-care workers.

“Moral integrity is the alignment between our moral beliefs and our actions,” explained Mike Kekewich, Director of Clinical and Organizational Ethics at The Ottawa Hospital. “When different circumstances or events disrupt this alignment, we are at risk of experiencing moral distress because we may feel we are doing the wrong thing.”

The risk of experiencing moral distress may be higher during public health emergencies or in situations when extreme resource limitations impact the safety or integrity of your work.

HOW TO IDENTIFY MORAL DISTRESS

“It is difficult to identify all potential sources of moral distress because it is difficult to identify all of the moral values held by different professionals,” said Dr. Nathalie Fleming, Medical Director, Physician Health and Wellness and Professor in the Department of Obstetrics and Gynecology at the University of Ottawa. Examples include:

- Feeling unable to perform your work to the level that’s needed because your workload is too high or you are too tired.
- Witnessing health-care providers giving “false hope” to a patient or family.
- Following a family’s insistence to continue aggressive treatment even though you believe it is not in the best interest of the patient.
- Feeling pressured to order or carry out orders for what you consider to be unnecessary or inappropriate tests and treatments.
- Watching patient care suffer because of a lack of provider continuity.
- Being unable to book or perform surgeries for patients who need them due to surgery backlog.
- Witnessing a violation of a standard of practice or a code of ethics and not feeling sufficiently supported to report the violation.
- Denying time off to staff members who clearly need and deserve it when staffing quotas cannot be met.
- Lack of clarity because the instructions or guidance you are given is constantly changing.

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Not everyone experiences moral distress the same way. Depending on the person and the event, it can range from being easily manageable to completely impairing.

HOW TO WORK THROUGH MORAL DISTRESS

Some level of moral distress is inherent in daily life and work, and for most people, this is easily manageable. However, studies on this topic note that moral distress has led to people leaving or considering leaving their jobs. Consider the intensity and frequency of distress, and whether it is something that needs to be addressed to be healthy and safe at work.

“It is important to identify and work through moral distress when it takes place because if you have multiple experiences of moral distress without a return to your normal baseline in between, they might become more difficult to manage as they build on each other,” said Dr. Kerri Ritchie, Clinical and Health Psychologist and Professional Practice Coordinator for the Psychology Department at The Ottawa Hospital. “This is similar to how someone might experience episodes of acute stress building into chronic stress.”

To learn more about moral distress, listen to “What is moral distress?,” an episode of On Call: The Ottawa Hospital podcast where Dr. Ritchie and Mike further discuss the topic.

And consult these resources for physicians by the Canadian Medical Association:
- COVID-19 and moral distress
- A clinician’s guide: how to manage morally distressing situations

Caitlin Renneson is a Content Writer at The Ottawa Hospital.

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Respiratory therapy students quickly immersed in COVID-19 ICU

By Gary Buffet

This year, more than ever, our health care system is relying on Respiratory Therapists (RT). As frontline workers, they have played important roles behind the front lines of the pandemic forcing RTs into new territory like never before.

“Pre-pandemic, a typically busy day had the three or four RTs caring for 24 or 25 ventilators,” says Ray Milton, Professional Practice Leader for Respiratory Therapy Services. “At the peak of COVID-19 activity there were approximately 65 ventilated patients, most of whom were sicker than we had ever seen. Normal coverage and tasks changed dramatically in order to meet the increased acuity and occupancy in newly expanded ICU spaces.”

To assist in meeting these needs, RT students provided care under supervision of RTs and new RT assistant (RTA) positions were created into which 11 students were hired. Students worked as RTAs on their days off or after student days were complete. They functioned at as high a level as possible within their training and limits of not yet having licenses to practice. This helped to free up RTs to perform the most vital tasks while RTAs set up and reprocessed ventilators and airway equipment, processed point of care blood gas samples, and anything else that needed to be done.

At KHSC, there are up to 15 RT students from Algonquin College and eight students from St. Clair College in their consolidating and final year. “Last year, once the students arrived, many people adapted in a rapidly changing environment to ensure that students had rich learning experiences that met all their learning objectives. Their education was fast-tracked while meeting learning objectives,” says Milton.

The KHSC staff responsible for coordinating student activities, the schools and the regulatory college were extremely responsive in making sure RT students could complete their education and obtain their licenses as soon as possible.

“As a student starting clinical at the height of COVID-19, I was quickly immersed in the ICU atmosphere and everything that comes with it,” says Rachael Hube. “The RT’s put a lot of trust in my knowledge and ability to care for patients and I truly believe that has helped me get to where I am today. Towards the end of my clinical experience an opportunity to become a respiratory therapy assistant presented itself.

“Working with COVID-19 patients so early into my career has enhanced my ability to work and think under pressure and implement critical thinking skills while being cognizant of providing excellent patient care in a high stress environment. We were fortunate enough to be fit tested for the P100 respirators, which have been indispensable in treating patients with COVID-19. It has afforded us the ability to continue to provide exceptional patient care and medical interventions without feeling like we are going to be...”

Advancing leadership development at London Health Sciences Centre through first in Ontario partnership

London Health Sciences Centre (LHSC) was thrilled to be the first hospital in Ontario to have an in-house leadership development program awarded with the LEADS certification from the Canadian College of Health Leaders (CCHL). This new partnership agreement was announced in October and will allow staff and physicians who participate in our internal Insight to Action (I2A) LEADerS Program to gain advanced standing for the Certified Health Executive (CHE) designation requirements.

Through this agreement, participants in the Insight to Action (I2A) LEADerS Program at LHSC will gain advanced standing for all the CHE designation’s requirements. This program offers individual leaders several benefits including support for lifelong learning in health services leadership, assistance with career advancement, peer recognition and serves as an essential career designation.

The collaboration with CCHL to create an internal program that helps leaders at LHSC to achieve excellence is an exciting step forward in our organization’s commitment to continuously improve opportunities for our people, and patient care with exceptional leadership. We recognized the need for an advanced offering and responded with the creation of our LEADS Learning Series, Insight to Action (I2A) LEADerS Program, and integrating the LEADS in a Caring Environment Framework throughout our talent and people initiatives.

The CHE designation is the only certification program for health leaders working in Canada, and this latest offering is one of the many exciting, important, and unique opportunities LHSC offers to its teams as part of an ongoing commitment to the professional growth and development of our people.
exposed or risk infecting our family and friends. We would not have been able to do our jobs effectively without adequate access to PPE.

“It was a very busy year but I am proud to say that I have learned so much already and I could not have done it without all the incredible RT’s that work at KHSC. I am extremely thankful for them and everything they do and cannot wait to see what the future holds for the RT profession,” says Hube.

Along with the students, RTs were redeployed from all over KHSC and beyond to help at the peak of our COVID-19 activity. “They came from the OR, Pulmonary function lab, Ventilator Equipment Pool, research, the community, and out of retirement,” said Milton. “Many had not worked in these environments in years or since their initial training. It was amazing how quickly they were able to adapt and provide excellent care under exceptional circumstances.

“I don’t think we could have accomplished what we did to care for COVID-19 patients without the help from these dedicated professionals working collaboratively with all members of the healthcare team.”

KHSC employs almost 90 RTs who work in diverse areas including the Ventilator Equipment Pool, Pulmonary Function Lab, operating room, acute care, critical care, labor and deliver, NICU, ED and at Providence Care Hospital.

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Sharing stories that foster education and understanding

By Dr. Jane Philpott

G reat stories have always had the power to bind people together – to fos- ter connections, education, understanding, and partnership. Compelling stories can help unify existing communities and forge new relationships.

Those goals are at the heart of the new digital collection of Cinq à Sept Research Talks from Queen’s Health Sciences. We have created an online home for the powerful, personal stories behind the health research taking place at Queen’s University – and we want to share them with the health professionals and scientists around the country.

Each of our speakers offers a unique, intimate view into the passions and goals that drive their work. It is my hope that their stories inspire professional development and create new research opportunities that cross disciplines, institutions, and geography.

One of the guiding principles of Queen’s Health Sciences’ new strategic plan, Radical Collaboration for a Healthier World, is to be interprofessional and cross-disciplinary – “to in-still a shared sense of purpose around solving the most pressing questions about human health.” When we were creating our plan, we talked about creating opportunities for “accidental collisions” – designing spaces and situations where silos break down – where historically isolated disciplines, people, and ideas might cross paths.

Our new Research Talks embody that vision. Cinq à Sept is inspired by the French tradition of gathering at the end of the workday. A reception, hosted near the university campus be-

Taking Action Against Workplace Violence

New prevention tools to support healthcare workplaces

Workplace violence is an occupational hazard healthcare workers know all too well. Violent incidents and acts of aggression experienced in the workplace can leave a lasting impact, affecting the worker’s physical and mental well-being and interpersonal relationships. If violent behaviours are tolerated within the workplace, the work environment and quality of care are likely to suffer.

Identifying, assessing, and controlling the risk of workplace violence is a crucial step in the prevention process. Public Services Health & Safety Association’s suite of Violence, Aggression and Responsive Behaviours toolkits are a leading practice for establishing effective workplace violence prevention programs within healthcare organizations. Developed in partnership with stakeholders from across Ontario’s healthcare sector, the tools focus on high priority topics that address the largest contributing factors and gaps in workplace violence prevention.

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The tools are already having a positive impact on how healthcare organizations prevent and manage workplace violence, with 89% of users reporting that use of the tools improved their processes, programs and systems related to workplace violence prevention and management.

Get started at workplace-violence.ca

Dr. Jane Philpott is the Dean of Queen’s Health Sciences and former Federal Minister of Health and Minister of Indigenous Services. Cinq à Sept Research Talks can be found at healthsci.queensu.ca/5a7
The Kingston Nursing Research Conference (NRC) will be celebrating 25 years of knowledge sharing at its March 2022 virtual conference.

“We are honoured to celebrate 25 years of this forum for knowledge-sharing, networking, professional development and learning more about research activities that are taking place right here in the Greater Kingston Area,” said Barb Patterson, Co-chair of the 2022 conference. “With two great keynote presenters and 17 abstracts submitted for presentations or poster displays, things are shaping up to be the best value we have ever offered for participants.”

As a nurse data scientist at the Centre for Health Innovation, keynote presenter Alex Hamilton is responsible for developing machine learning applications to support research and quality improvement initiatives within the Faculty of Health Sciences and Kingston Health Sciences Centre. Alex will share his knowledge in his presentation Nursing in the Age of Artificial Intelligence.

Keynote presenter Dr. Joan Almost, Associate Professor in the School of Nursing at Queens University, and Scholar in Residence with the Canadian Nurses Association will share her research on adapting mental health resources to support frontline workers working with homeless and street-involved communities affected by COVID-19.

Offering an excellent forum for exchanging nursing research on a wide variety of topics, other presentations scheduled for the day include: Nurses’ Experiences with Activating Rapid Response Teams; Comparison of efficacy of microRNA 155 (miR 155) as a novel biomarker in rheumatoid arthritis (RA) vs. systemic lupus erythematosus; Environmental Contaminants and the Disproportionate Prevalence of Type-2 Diabetes Mellitus among Indigenous Cree Women in James Bay; Glucocorticoid administration and hyperglycemia in adults with hematological malignancies; the Emotional Burden Living with Cardiovascular Disease-A Loss of Control; Understanding the COVID-19-Ontario Infection Prevention and Control [IPAC] Swat Team Experience in Long Term Care Homes through Poetry and Art.; and Using integrated knowledge translation to prepare gynecological cancer survivors and their caregivers for life after primary cancer treatment.

“Sharing and using research findings is vital to nurses’ professional practice and our capacity to use the best evidence to address the many healthcare challenges we face today,” says Dr. Joan Tranmer, Professor and Sally Smith Chair at Queen’s University’s School of Nursing. “Our annual research conference provides a valuable forum for highlighting how nurses are improving health care outcomes, both for patients, and for healthcare providers. The extraordinary challenges and pressures of the continuing COVID-19 pandemic make this knowledge-sharing even more important. Our first virtual conference was sold out, and although we continue to be restricted to virtual meetings, we anticipate our 2022 event will be equally successful.”

The Kingston NRC is jointly hosted by KGH Research Institute, Kingston Health Sciences Centre, Providence Care, Queen’s University, Registered Nurses Association of Ontario (Kingston chapter) and St. Lawrence College.
Working well, thriving together

By Suelan Toye

If you have ever taken a flight, you’ve probably listened to a flight attendant’s instructions on how passengers should put an oxygen mask on before tending to their loved ones in the event of an emergency.

This same thinking is at the core of Holland Bloorview Kids Rehabilitation Hospital’s newly expanded mental health strategy.

Launched in October, the Working Well strategy gives that critical oxygen mask to more than 1,000 hospital staff, as well students, volunteers and family leaders.

“We know from previous employee engagement surveys and from industry data that health-care workers are experiencing unprecedented levels of mental stress and burnout, which has been exacerbated by the ongoing global pandemic. Our new strategy is a whole-team approach that supports everyone in our Holland Bloorview community,” says Sarah Keenan, co-lead of the strategy and a business partner with the hospital’s organizational transformation and effectiveness team. “We need to do that in order to make sure we’re taking care of each other first before we can help others.”

Developed by a 17-member committee with stakeholders across the hospital, the strategy takes into account the complexity of workplace mental health through supports, programs and resources, from the individual to the organizational level – and all through the lens of inclusion, diversity, equity and accessibility.

The strategy builds on the wealth of resources Holland Bloorview already has in place such as its Employee and Family Assistance program, training for hospital leaders on managing mental health in the workplace and extensive coverage of mental health providers as part of employees’ benefit packages.

“At the heart of our strategy is creating a psychologically safe workplace,” says Joanne Azulay, the strategy’s second co-lead and manager of organizational transformation and effectiveness. “We see this strategy as a way to provide a compassionate and healthy work environment that values and promotes the mental well-being for our entire Holland Bloorview community.”

HIGHLIGHTS

WORKING WELL HIGHLIGHTS

A key component of the Working Well strategy is the Stress First Aid program. Launched earlier this year, the program is a self-care and peer support model for those working in high-risk occupations to assess and respond to stress reactions. Individuals and teams take a series of eight self-directed, short modules to help them recognize and address early signs of stress in themselves and in their peers. This resource has been adapted by Holland Bloorview from materials developed by the Schwartz Centre for Compassionate Care and the National Center for PTSD.

The strategy, housed on the hospital’s intranet site, also provides helpful mental health resources for employees, including educational videos on managing stress, work-life balance assessment tools, mindfulness techniques and links to community partners servicing mental health needs of specific groups such as racialized communities and those who identify LGBTQ2S+. Kim Jones-Galley, student coordinator at Holland Bloorview’s Teaching and Learning Institute and a member of the Working Well committee, collaborated with the student wellness planning team to create a comprehensive list of mental health resources, including links to community partners like the Kids Help Phone and Good2Talk, as well as school-specific online resources. Other plans in development by the student planning team include a student wellness survey.

Looking to the future, the Working Well committee, guided by its co-chairs Keenan and Azulay, will focus on preventing burnout in the workplace by expanding more services and supports for students and volunteers as well as offering staff more information on topics related to mental health and burnout. The committee is also inviting staff, students and volunteers to provide feedback anonymously to continue refining the strategy so that it can meet everyone’s unique needs.

“While the pandemic acted as a catalyst to highlight how important it is to take mental health very seriously, we are designing this strategy for the long term,” says Keenan. “It needs to be nimble to meet the changing needs of our community.”

Suelan Toye is a Senior Research Communications Specialist at Holland Bloorview Kids Rehabilitation Hospital.
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Remote monitoring programs for chronic heart conditions: Implementation considerations

By Brit Cooper-Jones

In the wake of the COVID-19 pandemic, there has been an interest in increasing the provision of virtual care across the country. One example of virtual care is the use of remote monitoring programs and devices for chronic cardiac conditions, such as heart failure, high blood pressure, atrial fibrillation, and cardiac rehabilitation.

What exactly are “remote monitoring programs”? They are programs delivered through technology and/or telecommunication that help to monitor heart-related health data. They may involve interactive components with care providers (like a family doctor or heart specialist) or be designed more for education and self-monitoring purposes. Examples could range from collecting physiological measurements such as blood pressure or heart rate readings at home, to using any of these measurements (plus or minus telehealth visits) to offer increased care, oversight of, or education about a chronic heart condition without always having to see the doctor face-to-face.

The literature supports remote monitoring programs for chronic heart conditions as being generally effective and well-received. However, there are few details in the literature about what the actual mechanisms of these programs are, for whom they are best suited (and most effective), and what it is about various program offerings that make them more or less successful. Additionally, the cost-effectiveness of remote monitoring programs is largely unknown.

But it turns out that the biggest question of interest for stakeholders and health care decision-makers at this time is less about the clinical effectiveness and cost-effectiveness of remote monitoring programs, and more about gaining a greater understanding into program mechanisms and implementation considerations.

Responding to this need, CADTH – an independent not-for-profit organization that reviews the evidence on various health-related topics – conducted an Environmental Scan that summarized the current state of remote monitoring programs across Canada. Remote monitoring programs presently exist in BC, Ontario, New Brunswick, PEI, and Newfoundland and Labrador. The Environmental Scan reviews the details of these programs (as well as programs currently in development), in addition to summarizing operational considerations reported at the site level (perceived barriers and facilitators).

Due to the high level of interest in this topic, the Environmental Scan was only a first step, and CADTH followed it up with a full Health Technology Assessment (HTA). The HTA included three sections: a realist review looking at program mechanisms, a perspectives and experiences review, and an ethics review. CADTH also engaged patients and caregivers directly to gain greater insight into how these programs work in their daily lives and the aspects and features that were seen as most important.

The Health Technology Expert Review Panel (HTERP) then reviewed all of the evidence and developed recommendations regarding key implementation considerations for remote monitoring programs. These recommendations were divided into five domains: patient and caregiver considerations, provider considerations, data and privacy, digital equity, and evaluation.

On the patient and caregiver front, the need for functional and easy-to-use technologies was a priority. Additionally, since technological literacy could be a barrier, the availability of technical support was a facilitator. The ability to address the needs of caregivers was highlighted, given that caregiver support could be either a barrier or a facilitator to uptake. And finally, due to the lack of evidence specific to potentially higher-needs populations (e.g., those in rural/remote settings, Indigenous peoples, people of low socioeconomic status, etc.), HTERP recommended consulting these groups to better understand their needs and priorities prior to implementing a remote monitoring program.

With regards to providers, HTERP recommended that remote monitoring programs, if implemented, be integrated into clinical practice guidelines and the clinical care pathway, as well as into electronic medical records. HTERP noted the importance of considering the potential increase in workload for care providers associated with remote monitoring programs, and the need to consider appropriate remuneration (as well as policies for patients accessing care outside of their jurisdiction).

On the data and privacy front, protecting consumers from third party use of data was key, in addition to considering how and where data is transmitted and stored. For digital equity, HTERP noted that it is important that remote monitoring programs do not create or exacerbate existing disparities in care. They highlighted factors such as the potential economic burden of bringing your-own-device models as well as the importance of not foregoing in-person care for higher-needs groups who may benefit. Finally, HTERP recommended that remote monitoring programs include an evaluation component to ensure program aims are met, and to help in assessing the cost-effectiveness of such programs moving forward.

More detail on each of HTERP’s recommendations for the successful implementation of remote monitoring programs can be found in the full report.

Brit Cooper-Jones is a knowledge mobilization officer at CADTH.
Ontario supporting not-for-profit long-term care homes

The Ontario government is now providing loan guarantees to make it easier for select not-for-profit homes to secure development loans from Infrastructure Ontario to help increase long-term care capacity in communities across the province – as part of a historic $6.4 billion investment to deliver 30,000 net new beds over ten years.

Speaking at the Rekai Centre at Wellesley Central Place in Toronto, Minister of Long-Term Care Rod Phillips said, “As part of our government’s plan to fix long-term care, we are making it easier for not-for-profit homes to secure financing by launching the Not-for-Profit Loan Guarantee Program. We are protecting our progress by fixing this decades-old problem so we can get shovels in the ground and help accelerate the development of long-term care homes in communities all across the province.”

Securing financing is a long-standing challenge to development faced by the not-for-profit long-term care sector. With the new Not-for-Profit Loan Guarantee Program, $388 million in lending from Infrastructure Ontario will be unlocked for not-for-profit long-term care homes. It will also reduce approved not-for-profit borrowing costs and has the potential to save not-for-profit long-term care homes approximately $62 million.

Increased not-for-profit capacity in the sector will also ensure that Ontario’s seniors have access to a range of choices and locations for their long-term care needs. The province will work with Infrastructure Ontario and eligible operators to identify the right projects for the inaugural round of this initiative.

This initiative is part of the government’s plan to fix long-term care and to ensure Ontario’s seniors get the quality of care and quality of life they need and deserve both now and in the future. The plan is built on three pillars: staffing and care; accountability, enforcement, and transparency; and building modern, safe, comfortable homes for seniors.

The third pillar is supported through ongoing investments and strategic initiatives which include working with long-term care partners to remove barriers to long-term care home development to improve and accelerate the development of long-term care beds – actions which are urgently needed to address the increasing demand for long-term care beds across the province.

• Building new long-term care homes and redeveloping existing older homes to modern standards is part of the Government of Ontario’s Long-Term Care Modernization Plan.

• The Ontario government has introduced legislation that, if passed, would improve the well-being of residents in long-term care and retirement homes, and ensure they get the care they deserve. If passed, the Providing More Care, Protecting Seniors, and Building More Beds Act, 2021 would repeal the current Long-Term Care Homes Act, 2007 and create the Fixing Long-Term Care Act, 2021. The Bill also includes proposed amendments to the Retirement Homes Act, 2010.

• Ontario plans to invest an additional $3.7 billion, beginning in 2024–25, on top of the historic $2.68 billion already invested, to support a new series of allocations for the development of 10,000 new and 12,600 redeveloped beds across the province. These historic investments would bring the total to $6.4 billion since spring 2019.

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Cultivating culture at Halton Healthcare

By Lea Batara

“It’s not enough to just talk about organizational culture and values at Halton Healthcare, it is a priority for leaders and team members alike to actively live and cultivate a high performing culture. As a result of that commitment, the organization shares strength and compassion to support both its communities and its team members.

“Our organizational culture is built on our core values of Compassion, Accountability and Respect, and our purpose, To Care” affirms Denise Hardenne, Halton Healthcare’s President and CEO, “allowing us to create a workplace focused on inclusion, high-performance and recognition.”

In addition to industry standard staff benefits and assistance programs, Halton Healthcare’s senior leadership team have prioritized several innovative programs that assert the organization’s commitment to its people and culture. A few examples include programs that connect and support team members such as Schwartz Rounds, Kailo Wellness, COVIDCare and Applause Recognition.

Halton Healthcare was one of the first community hospitals in Canada to host Schwartz Rounds, which were developed by the Boston-based Schwartz Centre for Compassionate Care, in September 2018. The Rounds provide a multidisciplinary forum for healthcare professionals to share difficult emotional and social issues that arise when caring for patients.

“The Schwartz Centre was established by Ken Schwartz, a healthcare attorney with terminal lung cancer who recognized the important value of the relationship between care provider and patient,” explains Dr. Stephen Chin, Hospitalist. “These Rounds are a testament to him, in giving us the opportunity to come together to talk about the complexities of our relationships with our patients, and the ways in which we can bring compassion into those relationships.”

Schwartz Rounds have been clinically proven to reduce stress, help prevent burnout and compassion fatigue, and enhance patient care among healthcare providers. “These Rounds were made possible through Halton Healthcare’s innovation grants program with support from our Kailo Wellbeing Program and Oakville’s hospitalist physicians,” adds Dr. Chin.

The Schwartz Rounds are one of the many programs offered as part of Halton Healthcare’s broader wellness strategy for staff, physicians and volunteers, through the Kailo Wellbeing Program. “Our wellness program offers a number of programs and services to help reduce stress and maintain good health,” adds Louisa Nedkov, Kailo Wellbeing Program, Halton Healthcare.

Since 2005, Kailo has supported well-being by embracing a body, mind, and spirit approach to health. Staff and physicians have access to gyms at Halton Healthcare’s hospitals in Georgetown, Milton and Oakville, plus free guided meditations and Pet Pause, where furry friends from St. John’s Ambulance visit hospital units.

While Pet Pause has been placed on an actual pause due to the COVID-19 pandemic, the Kailo program has added several efforts to support teams. Staff are provided with stress first aid pocket reference cards and posters reminding everyone to take a moment to check-in, re-centre and find grounding while at work. Kailo also hosts virtual workshops and sessions, with topics ranging from Financial Fridays and money-related advice to Meditation Moments with Buddhist Nuns.

During the pandemic, another support program arose, called COVIDCare. The COVIDCare team facilitated supportive sessions with healthcare teams and volunteers across the organization. “COVIDCare is a peer support program that started quite innocently,” explained Dr. Jon Sam, Paediatrician. “I realized after the first weeks of the pandemic, there was a great fear and uncertainty amongst my peers and staff, doctors, nurses, volunteers – everybody.”

The peer support groups each have roughly 10-12 individuals who gather in physically distant huddles, while larger groups are accommodated virtually.
COVIDCare introduced the idea that the bravery staff and physicians show does not end when they leave work and there is strength in solidarity, even outside the pandemic. “COVIDCare made a big difference in terms of spreading and triggering positivity, togetherness and bravery to face the pandemic,” Dr. Sam adds. “It’s not like we can reassure anybody that things are going to be okay, but certainly we can help people connect to each other and share our struggles.”

Recognizing staff and physicians for going above and beyond in their work is also a valued practice within the organization. At Halton Healthcare, this is demonstrated by the annual Applause recognition awards.

The Applause awards include Values Inspired Performer (VIP) Team and Individual awards, Leadership awards and awards of excellence and nursing from each of the hospitals. Each recognize staff and physicians who exemplify Halton Healthcare’s mission, vision and values. Each year nominations for the awards garner a lot of attention from co-workers and teams across the organization as staff and physicians are moved to publicly recognize the demonstrations of a lived culture among their colleagues. The nominations themselves are proof of the commitment to the organization’s culture and demonstrate a win for everyone. “We are proud of our culture and our people who keep it alive and thriving,” says Dr. David McConachie, Chief of Staff. “So we must continue to foster a high performance culture at Halton Healthcare.”

Thanks to the committed efforts of the organization, Halton Healthcare has been recognized as one of Canada’s Most Admired Corporate Cultures of 2021, by Waterstone Human Capital. This award is based on an evaluation of corporate culture over the past three years and highlights recipients who put culture at the centre of everything they do.

Lea Batara is the Coordinator, Communications and Public Relations at Halton Healthcare.
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