Workplace Safety in the Health and Community Services Sectors in Nova Scotia:

Consultation Findings

Prepared by Research Power Inc. as part of the development of a ***Workplace Safety Action Plan for Nova Scotia's Health and Community Services Sectors***

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Executive Summary

Introduction

To inform the work currently underway to develop a *Workplace Safety Action Plan for Nova Scotia's Health and Community Services Sectors* (with a focus on publicly-funded home care, long term care (LTC) and community services), consultations were conducted with stakeholders in the three sectors. This included frontline employees (direct care providers, housekeeping, dietary, maintenance, etc.), managers/supervisors, senior leaders, and others (e.g., union representatives, Nova Scotia Health Authority (NSHA) care coordinators/discharge planners, licensing and audit staff from the Departments of Health and Wellness and Community Services, etc.). Participants could provide input into the consultations via a number of methods, including large group consultation sessions, smaller focus groups, and an online survey. Over 1,000 people provided their input across all three methods. This report presents the findings from these consultations and will be used to inform development of the Action Plan.

Supporting Factors for Workplace Health and Safety

The following were identified as factors that positively influence workplace health and safety:

- **Occupational health and safety management systems and practices:** In almost all consultation sessions and focus groups, and some survey responses, participants mentioned aspects of occupational health and safety management systems, including: Joint Occupational Health and Safety (JOHS) committees; safe work practices (e.g., cell phones to allow for easy communication between workers and supervisors); safety policies (e.g., workplace violence prevention, safe lift and transfer); inspections; incident investigations; risk assessments; communication about safety issues; or strong return to work programs.
- **Staff supports and behaviours:** Participants in many consultation sessions and focus groups, and some surveys, described programs/supports for staff that helped promote workplace health and safety (e.g., wellness/healthy workplace initiatives, a strong team environment, and good communication), and the various behaviours and strategies that staff used to keep themselves safe (e.g., identifying hazards, wearing and using appropriate clothing and protective equipment).
- **Training and education to address health and safety issues:** About a quarter of survey respondents and participants in many consultation sessions and focus groups spoke about education and training, including being able to access/participate in training, the variety of programs offered, and the important role of AWARE-NS in supporting/offering training.
- **Work environment/conditions:** Participants in many consultation sessions and focus groups, and some survey respondents, described aspects of the work environment, such as access to needed equipment and supplies, clean and organized work spaces, newer facilities with more space and designed with ceiling lifts in mind, and adequate attention to outdoor/weather conditions (e.g., snow removal, lighting).
- **Culture:** In some consultation sessions and focus groups, and in about one fifth of survey responses, participants spoke about a positive workplace culture that supports safety, including employees who care about safety, employers who recognize and value the importance of safety, strategies to identify and address hazards without placing blame, and engaging employees in problem-solving around safety issues.
- **Leadership:** Participants in some consultation sessions and focus groups, and a few survey respondents, discussed managers/leaders who were caring/supportive of staff, accessible, knowledgeable about safety, and who helped to resolve safety issues.

Barriers/Challenges to Workplace Health and Safety

The following were identified as factors that negatively influence workplace health and safety:

- **Staffing:** In all consultation sessions and focus groups, and some survey respondents, issues related to staff were mentioned, including staff shortages, staff turnover, working alone, staffing levels that didn't take into account client/patient/resident (client) care demands, scheduling and pay structures, staff mental health, and the composition of workforce (e.g., age).
- **Work environment/conditions:** Challenges to worker health and safety posed by the work environment or working conditions were mentioned consistently by participants in most of the consultation sessions and focus groups, and some survey respondents. Challenges included time pressures, lack of equipment, travel requirements, working alone, hazards (e.g., clutter, pets), changes in a client's status, and the unpredictable nature of the work.
- **Culture:** In most consultation sessions and focus groups, and about one quarter of survey responses, participants described negative workplace cultures. For example, staff that do not work safely or support each other to work safely, staff that do not feel valued for their work, management/leadership that does not support/enforce workplace health and safety, and a culture of blame for safety incidents/near misses.
- **Clients/patients/residents:** In most consultation sessions and focus groups, and about one fifth of survey responses, participants discussed how the level of acuity/complexity of clients is higher now than it was in the past, that there is a lack of supports for clients (e.g., mental health supports, PT and OT, etc.), and the difficult expectations of family/caregivers.
- **Education and training:** Participants in many consultation sessions and focus groups, and a few survey respondents, noted lack of training on specific OHS topics, and difficulty accessing training due to issues such as lack of replacement staff, cost, and not hearing about opportunities.
- **Policies:** In many consultation sessions and focus groups, and in very few surveys, participants discussed policies at the government/system level, such as funding decisions/levels, policies/procedures for client placement, and the Key Performance Indicators (KPIs) recently established for home care. At the organizational level, specific policies were mentioned (e.g., travel time, breaks), as well as lack of enforcement of policies, and inconsistencies in policies between organizations.
- **Accountability:** About one fifth of survey respondents, and participants in some consultation sessions and focus groups, described a lack of accountability for unsafe practices at various levels, including the system, organizations, individual employees, and clients.
- **Leadership:** In some consultation sessions and focus groups, and a few responses to the survey, participants discussed issues with leadership. Some examples given were a lack of understanding of management/leadership of the daily work of frontline staff, the limited time of supervisors/managers to address worker health and safety, lack of follow up or accountability, and/or a lack of knowledge/skills related to health and safety.
- **Occupational health and safety management systems:** A few survey respondents, and some participants in consultation sessions and focus groups, described elements of the occupational health and safety management system that were inadequate, such as a lack of support for return-to-work for injured workers, risk assessments or incident investigations that are not conducted as they should be, and ineffective/uninformed JOHS Committees.
- **Communication and information-sharing:** In some consultation sessions and focus groups, and in a few surveys, participants discussed a lack of communication and information-sharing related to health and safety within organizations, and also in relation to sharing information about clients across settings/facilities, for example, when a client moves from hospital to a LTC facility or home care agency.

Opportunities and Supports

The following opportunities for improving workplace health and safety and supports needed to take advantage of these opportunities were described in the consultation sessions:

- **Staffing:** Participants in most consultation sessions and focus groups, and some respondents to the survey, identified opportunities and supports such as reviewing and revising staffing requirements and skill mix in light of current client care needs, ensuring a good supply of skilled and trained staff to fill positions, and developing strong supports for staff (e.g. safety mentoring for new staff and staff mental health supports).
- **Training and education:** In all consultation sessions and focus groups, and in some survey responses, participants spoke about providing more training on various topics, and supporting participation in training (e.g., providing staff replacement costs or providing training locally on site). The importance of consistency in training was also noted.
- **Accountability mechanisms:** Mechanisms to enhance accountability at the system, organization, employee, and client level were identified by participants in most consultation sessions and focus groups, and by a few survey respondents. For example, more inspections and safety audits, identifying organizations with high rates of injury and providing specific supports to them, ensuring leaders are accountable to employees for addressing safety issues and employees are accountable for their own actions, and accountability for clients who harm workers, while taking mental capacity into consideration.
- **Leadership:** In most consultation sessions and focus groups, and a few survey responses, participants discussed the need for greater leadership for safety, particularly emphasizing that leaders should have the skills and knowledge to address safety, should model safe behaviour, and should have a good understanding of the daily work of frontline staff and the safety issues and challenges they may face.
- **Safety culture and employee engagement:** In most consultation sessions and focus groups, and a few survey responses, participants mentioned the need to build a strong safety culture where violence is not accepted and client and worker safety are equally valued. Active and engaged employees are an important part of this safety culture.
- **Communication:** Participants in many consultation sessions and focus groups, and a few survey respondents, spoke about the need for strong communication practices such as communication within teams about client needs and safety, as well as the importance of having client information follow the individual through settings/providers (e.g., via case conferences or electronic record systems).
- **Funding:** In many consultation sessions and focus groups, and a few survey responses, participants spoke about the need for more funding for items like equipment, training, and staff.
- **Policy and legislation:** In many consultation sessions and focus groups, and a few survey responses, participants noted the need for consistent policies across the province, as well as the importance of updating the Homes for Special Care (HSC) Act to better reflect the needs of clients and support worker safety.
- **Work environment:** Participants in some consultation sessions and focus groups, and about one fifth of survey respondents, identified improvements that could be made to the work environment, such as addressing equipment needs, proper maintenance of work environments (including home/community settings), improved facility design, and providing appropriate security systems.
- **Occupational health and safety management systems:** In a few surveys, and in some consultation sessions and focus groups, participants spoke about strengthening occupational health and safety management systems, including providing incentives and recognition for positive performance on health and safety, strengthening JOHS Committees, implementing safety policies and practices, and supporting return-to-work.

- **Client assessment and placement:** In some consultation sessions and focus groups, and in a few surveys, participants spoke about adequately assessing clients when they first come in to the care setting, and on an ongoing basis to identify risks and needs, and ensuring clients are properly placed and supported based on this assessment.
- **Collaboration:** In some consultation sessions and focus groups, participants suggested greater collaboration and sharing of best practices and resources across all levels of the system, and both within and between organizations.
- **Awareness:** Participants in some consultation sessions and focus groups highlighted the importance of increasing awareness of clients and family members in relation to worker health and safety.
- **Health system/service delivery:** Participants in a few consultation sessions and focus groups spoke about needed changes to the broader health system or service delivery approach, such as creating a more integrated approach to care or investing in more LTC beds/more home care hours.

Family and Friend Caregiver Survey Findings

Family and friend caregivers help sick and injured people stay in their homes, or provide them with additional care and support in a facility setting. In order to inform the development of the *Workplace Safety Action Plan for Nova Scotia's Health and Community Services Sectors* and provide family and friend caregivers with an opportunity to share the things that impact both their own health and safety and that of paid care workers, a survey of family and friend caregivers was conducted. Almost 300 individuals completed the survey.

The survey findings suggest that family and friend caregivers do interact with paid care workers, are aware of the health and safety policies that apply to paid care workers, and generally feel comfortable discussing issues related to the worker's health and safety. The findings also indicate that family and friend caregivers are aware that homeowners have a responsibly to address issues that may increase the risk of injury for paid care workers, and have made changes to address safety concerns identified by paid care workers. Family and friend caregivers reported pressures on their own mental and physical health (e.g., increased stress, physical pain or discomfort as a result of giving care, etc.), which may have an impact on the health and safety of paid care workers as caregivers may be less able to address health and safety issues or assist paid care workers with providing care safely. Finally, survey respondents identified several actions that could help improve the health and safety of unpaid caregivers and paid care workers, including greater paid staff support for clients; strong communication between paid workers and family/friend caregivers about safety and the care needs of the client; greater consistency in the paid care worker providing care; greater access to equipment/supplies/technology to help care for clients at home; more efficient scheduling of home care workers to minimize travel; more education for paid care workers; and greater supervision of paid workers.

Conclusion

This report presents the findings from all three consultation methods (survey, focus groups and consultation sessions) conducted as part of developing the *Workplace Health and Safety Action Plan for the Health and Community Services Sectors*. The findings from these consultations will help inform the selection of actions for inclusion in the Action Plan.

Introduction

Background

Workplace injuries and fatalities can have significant negative consequences for workers and their families, and they can also negatively affect work productivity and increase costs for government and businesses. In Nova Scotia, the health and community services sector has one of the highest rates of injury and the largest number of claims to the Workers' Compensation Board of Nova Scotia (WCB) for time lost from work due to injury. This is a large sector of the Nova Scotia economy, and includes ambulance services, family and social services, home care, hospitals, nursing homes and residential care facilities, and special care homes. Because of the size of this sector, the high rate of work-related injuries and illnesses that could potentially be prevented, and the impact of these injuries and illnesses on quality of care, stakeholders have come together to develop a five-year *Workplace Safety Action Plan for Nova Scotia's Health and Community Services Sectors*. The Action Plan will provide overall direction for the health and community services sectors, with particular focus on publicly-funded home care, long term care and community services.

Project Overview

The work to develop the Action Plan includes a number of elements:

- Research to identify **best practices** for improving health and safety in the health and community services sector that could be potential actions included in the Action Plan.
- A review of the **current state of workplace health and safety** for the long term care (LTC), home care, and community services sectors in Nova Scotia, including identification of issues/challenges related to workplace health and safety, and the supports and programs already in place that contribute to improving health and safety in these sectors.
- **Consultations with a wide range of stakeholders** from the health and community services sectors across Nova Scotia through in-person sessions and a survey.
- Develop the **Action Plan**, taking into consideration the findings from the research and consultations. Stakeholders will be engaged in developing, reviewing, and validating the Action Plan. A high-level evaluation framework (logic model and performance indicators) will also be developed for the actions identified in the plan.

Project Governance

The work on the Action Plan is being led by AWARE-NS (Nova Scotia Health and Community Services Safety Association). The work is also guided by a Steering Committee and an Advisory Committee. Organizations such as WCB, the Departments of Labour and Advanced Education (LAE), Health and Wellness (DHW), and Community Services (DCS), the Nova Scotia Health Authority (NSHA), the IWK Health Centre (IWK), employers in the home care, long-term care, and community services sectors, and organized labour representatives are represented on the Steering and Advisory Committees. The Project Sponsors (senior representatives from WCB, DHW, LAE, and NSHA) have the final decision-making authority for project related activities. The Deputy Minister of Health and Wellness, as Project Owner, has approval authority for the final Action Plan. A consulting firm, Research Power Inc. (RPI), has been engaged to support the work.

Purpose of this Report

As noted above, consultations were conducted with the many stakeholders that have a connection with workplace health and safety in the home care, long term care and community services sectors. This report presents the findings from these consultations.

Consultation Approach

Purpose

The purpose of the consultations is to:

- Explore the issues, concerns and contributing factors pertaining to work-related injuries and illnesses in the health and community services sectors in Nova Scotia, with a specific focus on community services, home care and long term care work places;
- Explore what is currently working well to support health and safety in the workplace in these sectors using an appreciative approach (i.e., identifying assets, capabilities, resources, and strengths);
- Explore potential solutions to the issues that are practical in the Nova Scotia health and community services sectors; and
- Inform the development of the Action Plan.

Methods

Three methods were used to gather input through consultations:

- In-person consultation sessions with frontline employees and managers/supervisors working in LTC, home care, and community services;
- Focus groups (modeled after the employee/manager consultation sessions) with leaders and other key stakeholders in LTC, home care, and community services; and
- An online survey open to those working in or supporting the LTC, home care, and community services sectors.

The consultation methods and approach were designed by the consultant (RPI) and the Project Team, with the input of the Project Sponsors, the Steering Committee, and the Advisory Committee.

Employee/Manager Consultation Sessions and Key Stakeholder Focus Groups

The employee/manager consultation sessions focused on gathering feedback from frontline employees (direct care providers, housekeeping, dietary, maintenance, etc.) and managers/supervisors working in LTC, home care, and community services, including Adult Residential Centres (ARCs) and Regional Rehabilitation Centres (RRCs), small options, and Adult Service Centres (ASCs) and social enterprises. The focus groups were targeted at senior leaders (i.e., CEOs, Administrators, etc.) and other key stakeholders in these sectors.

Twelve employee/manager consultation sessions were held, 3 in each of the 4 Zones (Halifax – Central Zone, Sydney – Eastern Zone, Yarmouth – Western Zone, Truro – Northern Zone). In each location, two sessions were held for employees (one in the morning and one in the evening) and one session for managers/supervisors. Each session was approximately two hours in length. Multiple times were offered for employees to support participation by those working different shifts. Separate sessions were held for employees and managers/supervisors so that participants would feel comfortable giving honest feedback.

Focus groups were coordinated with the identified key stakeholder groups to set up times that were convenient for them and/or to conduct the focus group in coordination with an existing/established meeting. The identified stakeholders for the focus groups include: Continuing Care Council, Community Governed Organizations, Home Support Network, DHW and DCS licensing and audit staff, ARC/RRC Association, and Continuing Care Coordinators and Discharge Planners. Focus group sessions were shorter than the employee/manager consultations, typically 60-75 minutes. All focus groups took place in Halifax.

All focus groups and employee/manager sessions were facilitated by an experienced facilitator who worked to establish an environment of trust, equity and empowerment. A blend of large and small group work was used to explore shared issues across the sectors, as well as the unique challenges faced in different settings. Over the course of each session, participants were asked to respond to the following questions:

- What are the factors that influence worker health and safety in your workplace, both positive and negative?
- Considering the positive and negative influencing factors identified, what are the best opportunities for improving workplace health and safety in your workplace? What is needed to take advantage of these opportunities in Nova Scotia?

To identify the positive and negative factors that affect workplace health and safety in the LTC, home care and community services sectors in Nova Scotia, a process was used that engaged participants in identifying and organizing these factors. In the employee/manager sessions, participants broke into small groups organized by setting (i.e., home care, LTC, small options homes, ARC/RRC, etc.) to discuss the positive and negative factors that influence worker health and safety in their workplace. In the focus groups, this was typically done as a single group as all participants were from the same setting. During the discussion, participants wrote down all positive and negative factors they identified on large post-it notes. The facilitator then supported participants (if they had broken into small groups, they came back together to do this activity as a large group) in grouping the post-its into “themes” (i.e., grouping together those factors that are similar/related) and naming these themes. This method of having participants actively conduct the theming of the factors ensures that the findings reflect the intention and meaning of the participants.

Online Survey

An online survey was developed to gather input from those working in, or helping to support the home care, long term care and community services sectors in Nova Scotia. The survey used very similar questions to those in the consultation sessions and focus groups:

1. In your view, what makes your work/workplace safe?
2. In your view, what makes your work/workplace unsafe?
3. How could your work/workplace be made safer?

Survey respondents were also asked some demographic questions about their work setting, their role, their geographic location, and whether they had filed a claim with WCB Nova Scotia as a result of a work-related injury or illness. A copy of the survey questions is provided in Appendix A of this report.

The survey was available online between February 5 and March 3, 2017.

Promotion of Consultations/Survey

Multiple channels were used to promote the consultation sessions and survey. These included:

- Invitations to attend employee/manager consultation sessions and to complete the online survey were sent using the AWARE-NS database, which has an extensive listing of contacts for those working in the sectors of interest. All participants in the in-person consultation sessions also received an invitation to complete the survey.
- The employee/manager sessions and online survey were promoted through AWARE-NS newsletter and communication channels and during training sessions hosted by AWARE-NS.
- The Project Advisory Committee and Steering Committee members promoted the employee/manager sessions and online survey using email, newsletters, and social media networks.
- The employee/manager sessions and online survey were promoted in sector newsletters, at sector meetings and forums (DHW Continuing Care, Health Care Human Resources Sector Council, HANS, WCB Case and Relationship Managers, Department of Labor network).
- DHW offered reimbursement for staff time to LTC and home care organizations to assist them with backfilling staff positions to allow staff to attend the employee/manager consultation sessions.
- The Project Team worked with identified key stakeholder groups (Continuing Care Council, Community Governed Organizations, Home Support Network, DHW and DCS licensing and audit staff, Adult Residential Centres and Regional Rehabilitation Centres (ARC/RRC Association), and Continuing Care Coordinators and Discharge Planners) to set up times to conduct focus groups to gather their input.

Participation

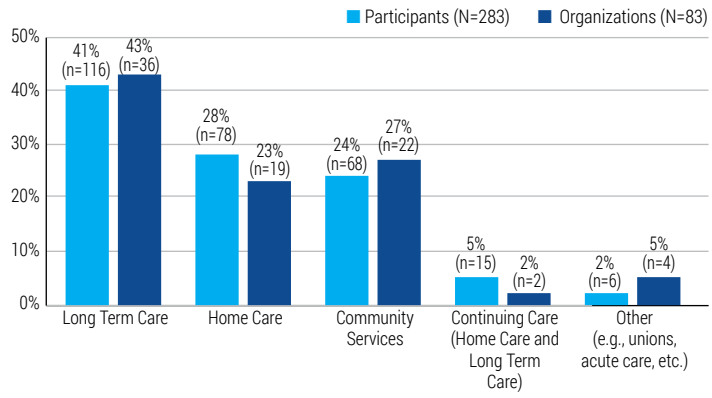
Employee/Manager Consultation Sessions and Key Stakeholder Focus Groups

A total of 283 participants representing 83 organizations in the health and community services sectors participated in the employee/manager consultation sessions or the focus groups with key stakeholders. This included 71 participants in six key stakeholder focus groups and 212 participants in 12 employee/manager consultation sessions. Half of the participants (106) in the employee/manager consultation sessions were managers/supervisors, and the other half employees. About a third of participants in employee/manager consultation sessions attended consultations in Halifax (34%, n=73) and Sydney (30%, n=64) respectively, 20% attended the sessions in Yarmouth (n=42), and 16% (n=33) attended the sessions in Truro.

Figure 1 describes the participants in both the employee/manager consultation sessions and the key stakeholder focus groups by sector.

As is reflected in the figure, the greatest proportion of participants were from LTC, followed by home care and community services.

Figure 1: Employee/Manager Consultation and Focus Group Participants by Setting



About half of participants were involved in their organization's Joint Occupational Health and Safety (JOHS) Committee. A smaller proportion of participants coordinated return to work and/or coordinated claims management, and most of these were managers/supervisors or senior leaders. Of the 136 people who said they were involved in JOHS Committees, the majority were managers/supervisors/senior leaders (63%, n=85).

Table 1: Employee/Manager Consultation Participants by Participation in OHS Activities

OHS Activity	Participants	
	#	%*
Involved in JOHS Committee	136	48.4%
Coordinate Return to Work	66	23.5%
Coordinate Claims Management	50	17.8%

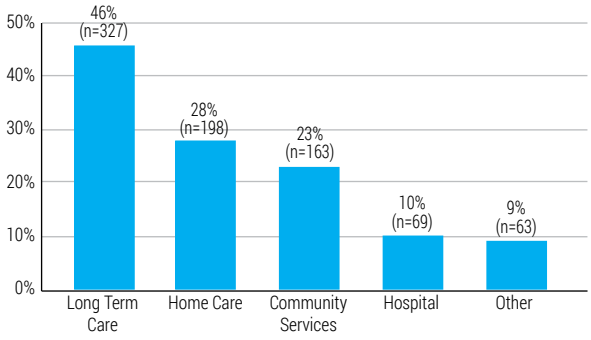
** Percentages do not sum to 100% as participants could select more than one option, or no options.*

Online Survey

A total of 747 respondents completed the online survey. Two of the surveys indicated that they were responses on behalf of a JOHS Committee, bringing the total number of individuals participating in the survey to 770. Survey responses were voluntary (i.e., no question was required to have a response before moving forward), so not all respondents answered every question. Percentages presented here for the demographic data were calculated individually for each question and based on the number of unique respondents that answered that question.

As seen in Figure 2, almost half of survey respondents were from LTC (nursing homes or residential care facilities), while about a quarter were from home care and a quarter from community services (small options/group homes, ARC/RRC, and/or Adult Service Centres/social enterprise).

Figure 2: Survey Respondents by Setting (N=717)*

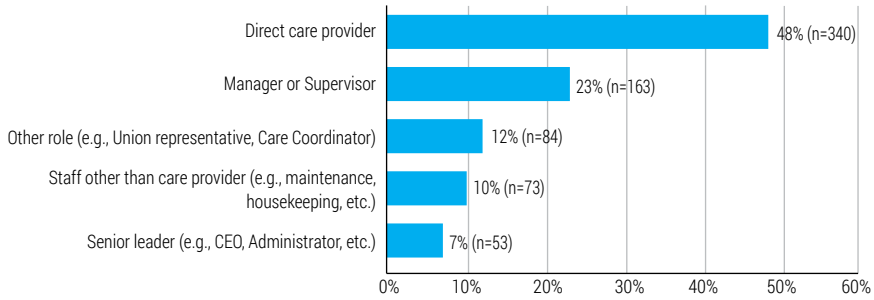


** Percentages do not sum to 100% as participants could select more than one option, or no options.*

Although 69 respondents (10%) indicated that they worked in a hospital setting, the majority of these (56 of 69, 81%) also worked in other settings such as LTC or home care. Only 13 respondents (1.8% of 717) indicated they worked only in a hospital setting.

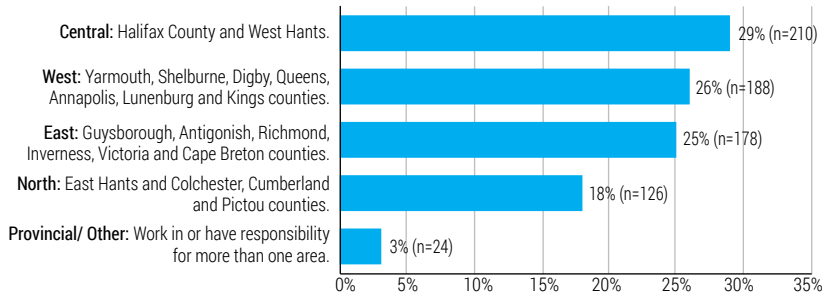
As seen in Figure 3, almost half of survey respondents were direct care providers, and almost a quarter were managers/supervisors.

Figure 3: Survey Respondents by Role (N=713)



Survey respondents were spread fairly evenly across the central, western, and eastern parts of the province, with fewer respondents from the northern area (see Figure 4).

Figure 4: Survey Respondents by Location (N=717)*



** Percentages do not sum to 100% as participants could select more than one option, or no options.*

Over a third of survey respondents (36%, n=256 of 706) indicated that they had filed a claim with WCB Nova Scotia as a result of a work-related injury or illness.

Analysis

Information collected through the consultations was thematically analyzed, which involves identifying common threads across sources (i.e., consultation/focus group notes, survey responses). Qualitative analysis software, Nvivo (version 10), was used to complete the analysis. Sources were first coded to reveal broader themes, as well as sub-themes/categories that illuminate the data in ways not provided by the main themes/concepts. The themes and sub-categories were then compared and contrasted across data sources to further formulate the themes and categories. Systematic comparisons and verifications ensure that important categories are not overlooked, and that emerging categories and concepts are properly identified.

As described above, employee/manager consultation and focus group participants were actively engaged in identifying and theming the positive and negative factors that affect workplace health and safety. These high-level themes created by session participants were used by the consultants to organize the findings presented in this report. Additional themes emerging from the survey respondents but not reflected in the consultation sessions and focus groups were added where relevant.

The strength of response for each theme is reflected in the order in which the themes are presented (those mentioned most frequently are presented first), and in the use of the descriptors "most", "many", "some" and "a few".

- "Most" is used when a theme was mentioned by approximately 80% of participants or greater.
- "Many" is used when a theme was mentioned by approximately two-thirds to 80% of participants.
- "Some" is used when a theme was mentioned by approximately one-third to two-thirds of participants.
- "A few" is used when a theme was mentioned by fewer than a third of participants (for survey respondents, "a few" is used when less than 10% of respondents mentioned the theme).

Direct quotations from survey respondents are also included to illustrate the themes. Direct quotations were not recorded in the focus groups and consultation sessions and are therefore not available to be included in the report.

Limitations and Considerations

- Some discussions in the focus groups and employee/manager consultations were focused on a few issues and time did not always allow for other issues to be fully explored, or for the quiet, unassuming members to share their views.
- The attendance at the employee/manager consultation sessions was lower than anticipated. Although sessions occurred in four locations across the province, travel distance may still have been a factor in preventing people from other locations from attending. The much higher response rate to the survey (770 respondents) demonstrates that there is strong interest in providing feedback on this topic.

Findings

Factors Affecting Workplace Health and Safety

As described in the Consultation Approach section of this report, consultation participants and survey respondents were asked to identify the positive and negative factors that affect workplace health and safety in the LTC, home care and community service sectors in Nova Scotia. This section describes the identified factors.

Supporting Factors

Participants in the three consultation methods identified many positive factors that support workplace health and safety. The word cloud in Figure 5 reflects the top 25 words used by survey respondents when describing the factors that make their work/workplace safe.

The themes identified by all consultation participants (consultation sessions, focus groups, survey) include: safety management systems and practices; staff supports and behaviours; education and training to address health and safety concerns; a work environment that supports safety; a workplace culture that prioritizes and supports health and safety; leadership support for health and safety; and others (e.g., partnerships, accountability of unsafe behaviour, model of care, use of technology, etc.). The supporting factors are described in order of the strength of response for each factor, i.e., those mentioned most frequently are presented first.

Figure 5: Word Cloud of Top 25 Words Related to Supporting Factors

Occupational Health and Safety Management Systems and Practices

In almost all the consultation sessions and focus groups, participants consistently spoke about the role of occupational health and safety management systems and practices in supporting workplace health and safety. Some survey respondents also spoke about safety systems and practices. Participants/respondents spoke about the following elements:

- A visible and active JOHS Committee.
- A range of specific preventative safety practices, such as use of mobile phones as a communication and tracking tool or use of equipment such as Wander Guard bracelets for patients/residents in long term care or panic buttons for staff.
- Regular inspections to identify hazards and/or reporting of identified safety issues.
- Techniques to communicate about health and safety such as team meetings, safety huddles, daily continuous improvement talks/meetings, case conferences.
- Safety-related policies such as those addressing workplace violence and/or high risk clients, safe use of lifting equipment, client use of drugs/alcohol, code white policy, etc.
- Conducting risk assessments (e.g., workplace violence risk assessment, using the PACE tool, job hazard analysis, etc.) and developing and following plans to address those risks/hazards (e.g., emergency plans).
- Appropriate investigation and follow-up to address incidents or safety hazards.
- Tracking systems to track things like safety incidents, violent incidents, equipment maintenance, etc.
- Having a strong return to work system and supports (e.g., access to physio or occupational therapy), and debriefing about the causes of injuries.
- Holding staff accountable for safe practices.

Having an up to date Occupational Health and Safety policy binder with a supervisor who ensures staff have an understanding of the policies and procedures in place.

Communication is the number one component to a safe workplace environment.

Effective reporting by staff regarding changes in a client's situation and needs in order to prevent future staff from incurring injuries.

Having an active JOSH Committee. There is a difference in having a committee that exists and one that is very eager to listen and make changes and looking to move forward all the time.

Having access to a cell phone/smart phone to call for help if needed.

Safety inspections are done on a monthly basis and any issues that arise are remedied right away.

Environmental Risk surveys being done on every client upon admission to services and ongoing as needed.

Staff Supports and Behaviours

In many consultation sessions and focus groups, and in some surveys, participants spoke about the programs and supports for staff that helped to promote workplace health and safety, and the various behaviours and strategies that staff used to keep themselves safe. Supports for staff included the effective way teams communicate and work together (e.g., regular team meetings, team approach to problem-solving and/or providing care), the availability of wellness programs and supports (e.g., Employee Assistance Programs, wellness/healthy workplace programs), supervision provided to staff, and appropriate scheduling/work assignments (e.g., assigning male staff to certain clients, consistency in the care provider working with a client, limits to hours of work based on collective agreements, etc.).

The behaviours of staff that helped to support safety were also described by about 15% of respondents to the survey. These behaviours included being aware of their surroundings and potential hazards, taking the time to work safely, having a positive attitude, and following safety practices (e.g., wearing appropriate footwear, proper body mechanics in lifting).

> *Caring individuals who work together as a team.*
>
> *The ability of the front-line staff to identify unsafe situations, and to approach supervisory staff and necessary people (physio, OH&S) to discuss and problem solve.*
>
> *When all workers are practicing safe work habits and take the time to do things right the first time.*
>
> *Following proper procedure and protocol in all aspects of work (i.e. proper body mechanics, safe handling of cleaning products, utilizing equipment properly).*

A few survey respondents and focus group/consultation session participants noted that the experience, knowledge and skill level of some staff was helpful in supporting health and safety.

> *Knowledge and awareness of risk factors by all staff.*
>
> *Staff members are trained in techniques to help protect ourselves.*

A few survey respondents spoke about the importance of having adequate staff to facilitate working safely.

> *Having enough staff to make sure all aspects of safety are covered.*

Education and Training

In many sessions/focus groups, participants consistently identified education and training as a positive factor in workplace health and safety. This was also mentioned by about a quarter of survey respondents. Participants/respondents said that the training provided was an important support. They identified specific helpful training programs including S.A.F.E.R. Leadership, P.I.E.C.E.S, GPA (Gentle Persuasive Approach) training, Low Arousal, Non-Violent Crisis Intervention, Compassion Fatigue, JOHS Committee training, Safe Handling and Mobility/PACE, training in body mechanics, training in working with bariatric clients, training on how to use the bed mobility program, and training provided by the Alzheimer's Society. Participants in some sessions/focus groups mentioned the important role of AWARE-NS in providing training. In a few sessions/focus groups participants also described training/education received as part of orientation for new employees, the availability of training/education opportunities using technology, and client-specific training as positive factors. Education/training for supervisors/managers about safety as well as general supervisory skills was also mentioned in a few sessions/focus groups.

Education is critical to a safe workplace. Ensuring staff have the resources, skill and knowledge is our priority for a safe workplace.

We have numerous safety education opportunities as well as annual education to complete. We have a Back to Basics program which is mandatory.

Managing Challenging Behaviour training.

Staff education: NVCI, Safe Resident Handling, PIECES.

Work Environment/Conditions

Participants in many consultation sessions/focus groups, and some survey respondents spoke about aspects of their work environment that supported health and safety. Elements of the work environment that were mentioned included access to and proper maintenance of the equipment and supplies needed to work safely (e.g., lifts, slider sheets, hospital beds); work environments that are clear and organized; new facilities with more space and equipment; working in a locked/secure environment; outdoor/weather conditions that are addressed (e.g., proper outdoor lighting, snow and ice removal, etc.); and the availability of other resources to support clients/patients/residents (e.g., occupational therapists (OT), physical therapists (PT), challenging behaviour consultants, etc.).

Having the tools that we require to aid us in our work such as transfer sheets, electric beds, portable and ceiling lifts, buddy system, well maintained equipment and response of maintenance staff.

Buildings that are in good repair.

My work place has very good protocol in place regarding lights in the parking lot, regular snow removal and de-icing.

PPE provided to staff.

Home with pets put away, walkways clear.

Culture

In some consultation sessions/focus groups and in about one-fifth of survey responses, participants spoke about factors that contributed to a positive workplace culture that supports safety. Participants noted that employees care about safety and look after themselves, each other, and clients/patients/residents. Employers prioritize and acknowledge workplace health and safety, and provide recognition and support for identifying and addressing safety hazards, without placing blame. Engaging employees in problem-solving around safety issues was also mentioned in a few sessions/focus groups.

Safety is a key value – it is taken seriously, discussed often, strategies to be safe, education, etc.

Safety is a priority when all workplace partners actively demonstrate that the health and safety of staff is important and invest time in creating that culture of safety. This is an active commitment beyond a binder on a shelf.

Staff know when to report incidents and when to not perform unsafe work without the feeling of being in trouble.

Incentives for staff to promote safety culture in their workplace (versus threatening employees when they bring risk issues forward).

A no blame culture so that near misses and accidents are reviewed to ensure future prevention.

A team who takes the safety of their staff/clients/residents/family members very seriously.

Coworkers who care about their job and are ready to help each other when needed.

Leadership

Participants in some consultation sessions/focus groups and a few survey respondents described leadership as an important contributing factor to workplace health and safety. Participants primarily described managers/supervisors who were caring/supportive of staff, accessible (i.e., supervisors were available to observe and support staff), knowledgeable about safety, and who helped to resolve safety issues. A few participants/respondents also mentioned senior leadership such as Boards, CEOs, Administrators, etc.

Leadership providing direction, support, education, and resources to create a safety oriented culture.

Support from management to follow through with required steps to improve safety.

Frequent supervision of staff by managers being present on the floor and observing staff while working.

A management that will support, practice and enforce adherence to their safety policies.

The commitment to safety demonstrated and upheld by Senior Leadership, Management and the Board of Directors as evidenced by our strategic priority.

Other

Each of the following themes were mentioned in a few consultation sessions/focus groups, and/or by a few survey respondents (less than 10%):

- **Accountability** for working safely.
- **Union support** for employees, including providing training.
- Appropriate **care plans** are in place for each client/patient/resident, and are updated as needs change.
- Use of the **Eden model of care**.
- **Partnerships** and working collaboratively with other organizations and resources such as the WCB, LAE, Unions, Care Coordinators, palliative care resources, etc.
- Improved **compliance with regulations** and enforcing health and safety practices.
- Clients/patients/residents have **access to funding** to provide additional supports.
- **Technology** that supports safety (e.g., to share information, communicate).
- **Legislation** that supports health and safety (e.g., Occupational Health and Safety Act, other regulations and codes of practice).
- **Licensing and inspection/audit** practices that address safety issues/concerns.
- **Adequate resources/funding** to respond to needs related to workplace health and safety.
- **Supports for families** such as developing back up plans if care cannot be provided to an individual (particularly in the context of services delivered to a person's home)

Barriers/Challenges

Consultation participants spoke about the factors that are barriers or challenges to workplace health and safety. The word cloud in Figure 6 reflects the top 25 words used by survey respondents when describing the factors that make their work/workplace unsafe.

The themes identified by all consultation participants (consultation sessions, focus groups, survey) include: issues related to staffing (e.g., staff shortages, schedules/pay structures, staff mental health, the composition of the workforce); the work environment (e.g., time pressures, lack of equipment/supplies, travel conditions, the home environment of home care clients, working alone); culture (e.g., staff do not work safely, staff do not feel valued for their contributions, culture of blame for incidents/near misses); clients/patients/residents (e.g., complexity/acuity, challenging behaviours); education and training (e.g., lack of training, barriers to training); policy (e.g., limitations on available funding, improper placement of clients/patients/residents, organizational policies that don't support safety); accountability (e.g., a lack

Figure 6: Word Cloud of Top 25 Words Related to Barriers/Challenges

of accountability for unsafe practices); leadership (e.g., manager/supervisors lack time or knowledge/skills to address safety issues); safety management systems (e.g., lack of support for return to work after an injury); and communication and information-sharing (e.g., a lack of or barriers to sharing information related to workplace health and safety). The barriers/challenges are described in order of the strength of response for each barrier/challenge, i.e., those mentioned most frequently are presented first.

Staffing

Barriers related to staffing were discussed in all the consultation sessions/focus groups and by some survey respondents. The most frequently mentioned aspect of this (discussed consistently across consultation methods) was a shortage of staff. Staff shortages contributed to concerns such as staff burnout and fatigue due to long hours and/or heavy workload, a lack of specific expertise (e.g., in workplace health and safety, return to work, maintenance, OT/PT), rushing to accomplish tasks leading to unsafe actions, and staff working alone. Various factors that may contribute to the staff shortage were mentioned, including the existing requirements for staffing levels that may not be sufficient to address the care needs of clients/patients/residents, staff turnover, and a lack of sufficiently trained new staff. Staff turnover may contribute to a lack of continuity of care as well, leading to a new employee working with a client/patient/resident on each encounter/visit.

> *When I say not enough staff I mean that our FTEs are not sufficient for the health and safety of our residents.*
>
> *Only one staff on at night for 13 residents.*
>
> *Unsafe staffing levels when staff are not replaced and staff have to make the best of it… this is frustrating and can lead to injuries.*
>
> *Being understaffed and having the pressure of doing the same amount of work as when you are fully staffed.*
>
> *We often work way short staffed and are stretched to our limit and still being asked/made to do more.*
>
> *Being short staffed makes us rush, therefore we are not as careful as we should be.*

Participants in some consultation sessions/focus groups and in a few survey responses described challenges with scheduling and pay structures for staff. For example, some home care staff do not get paid for gaps in their day (e.g., if a visit is cancelled), shifts for staff are not scheduled consistently (e.g., mix of nights/days), it may be difficult to take breaks, staff may work split shifts or double shifts, etc. It was also noted that shift work can have an impact on staff mental health.

Poor work schedules (two days, off two, two nights, off two).

Too many visits, increasing fatigue and therefore injury from tired bodies that are not machines.

I do not mind split shifts but having 8 hours break between calls is unnecessary and makes for a very long day, which makes us exhausted being out from early morning until late at night every day.

Sometimes we don't get a break by the time we travel from place to place. Travel time is not included in the schedule so might have break listed but by the time you travel, no time to rest.

Staff mental health was mentioned in some consultation sessions/focus groups and by a few survey respondents. Participants/respondents indicated that staff are under stress and/or dealing with their own mental health issues, and do not have enough supports in place to help them with this. In a few sessions/focus groups, participants also indicated that the financial situation of staff might influence them in working unsafely (e.g., feeling unable to refuse work that is unsafe because they need the money).

Mental health is the biggest challenge in dealing with both clients and staff.

Stress levels are rising.

The composition of the workforce was discussed in a few sessions/focus groups and mentioned by a few survey respondents. For example, staff may be older, they are not physically fit or are dealing with their own health issues (e.g., smoking), or language barriers to communication among team members.

Work Environment/Conditions

Challenges to worker health and safety posed by the work environment or working conditions were mentioned consistently by participants in most of the consultation sessions/focus groups, and by some survey respondents. The challenges described included:

- Time pressures, feeling rushed, and a lack of rest/breaks or needing to work longer to accomplish all the required tasks.
- Necessary equipment that is lacking or requires repairs (e.g., no lifts, no hospital beds in a home setting) and/or a lack of supplies (e.g., gloves, gowns).
- Travel requirements and weather conditions such as winter weather, lack of snow removal, parking issues, etc.
- Working alone/unsupervised.
- Hazards related to the facility or to the client's home such as lack of space for working safely, physical separation of staff that are working in the same facility, unsafe conditions in a client's home (e.g., clutter, unsanitary conditions, smoking, pets, etc.), building structures that are in disrepair (roofs, stairs), temperature too warm/too cold, poor air quality, etc.
- Changes in the client/patient/resident's status (may change frequently) and a lack of support to address this.

- Lack of a secure unit or doors (i.e., no ability to lock down the area or prevent external people from coming in).
- The overall unpredictable nature of the work.

A feeling that staff have to work alone in order to keep care moving along, i.e., they can't wait for the second person because there is too much to do.

Sometimes work gets so focused on getting the job done in the quickest amount of time that people rush and get hurt in the process.

Not having the proper equipment for staff to work with, example wheelchairs that are not user-friendly, bathtubs that are not suitable for the clients that we support.

Equipment that is not working properly and has not been serviced on a regular basis.

Poor ergonomics in work stations.

We have to drive a lot which puts us at greater risk of car accidents than people who are not on the road as much.

Working alone is hard physically in situations where the person is difficult to roll or is fighting against you because they may not understand your purpose is to help them.

Working in remote locations in the dark evenings, alone and with no cell coverage.

When hospital beds are pushed up against the wall due to lack of room and you cannot move the bed to do care from both sides, you have to do a lot of reaching. When the bathroom is too small for you and your client. When the client's bed is so low it is hard to do care.

Lack of snow removal and depending on the staff to get it done when they are busy elsewhere.

Small work spaces with much to trip over and bump into.

Security never asks for ID, we do not have a secure unit for the type of patients we care for, we do not have panic buttons, the doors to the building are not always locked when they are supposed to be.

The unknown, going to a client's home for the first time as you don't always know if they have pets, are mentally unstable or other occupants in the home could be unstable and threaten your life.

As the vast majority of employees in the organization work in assigned homes and in the community supporting adults with intellectual, psychiatric and physical disabilities, the workplace is ever changing and can therefore be unpredictable.

Culture

In most sessions/focus groups, participants discussed workplace cultures that do not support worker health and safety. This was also mentioned by about a quarter of survey respondents. The main challenges described include staff that do not work safely (e.g., take unnecessary risks, do not follow policies/procedures, resistance to changing to safer practices/continuing unsafe habits etc.); staff that do not feel valued for their work/contributions to safety (discussed by both employees and managers); low morale; a culture where staff do not support one another in working safely; management/leadership that does not support/enforce workplace health and safety; a culture of blame for safety incidents/near misses; and a culture that prioritizes the safety and care needs of the resident/client/patient above the safety of staff.

The employees who continue to do things the way they always have instead of using the training they have received to do resident care properly and safely.

Not taking our time to do what is needed.

Staff not caring or thinking its someone else's job to fix something they may come across.

In my opinion, the leading factor that results in an unsafe workplace is staff not being open to change, resisting new practices and procedures that are designed to improve their safety.

When issues arise, management is unwilling or unable to sit down and listen to staff concerns.

That decisions about safety and policy surrounding it are made by people who have office jobs and do not include input from relevant staff.

Blame culture.

There is still a longstanding culture of doing all that one can for clients – even at the expense of one's safety – which I must admit, a lot of staff still do not recognize as being potentially unsafe for themselves and having the potential to accumulate and cause future problems.

The pressure we feel to do our job and to provide care even when it isn't completely safe.

Clients/Patients/Residents

Participants in most consultation sessions/focus groups identified health and safety concerns related to clients/patients/residents. This was also discussed by about one fifth of survey respondents. Factors mentioned included:

- Clients have a higher level of acuity and complexity than they used to, meaning they require a greater level of care from staff. Issues such as dementia, mental health challenges, and challenging behaviours are more common, as are bariatric clients. There are also more residents that may have mental health challenges but are younger and more physically able.
- Client/patient/resident needs may not be assessed in a timely manner, or not re-assessed frequently enough.
- There is a lack of accessibility of other services and supports for clients/patients/residents (e.g., mental health supports, PT and OT, etc.).
- The expectations and behaviour of family members or other caregivers can sometimes pose risks to health and safety.

Increasing dementia clients with behavioural challenges. Violence encountered very frequently.

High acuity/complex medical diagnosis residents versus staff availability/mix.

The increased challenges faced with resident(s) cognitive disorders and related behaviours.

The unpredictable behaviors of younger residents diagnosed with mental health issues which presents as aggression.

Workers get hit, bitten, punched etc. just trying to provide basic care and then we get shot down by families when they come in and see them dirty.

When resident needs and abilities are not adequately assessed, documented and communicated.

Inappropriate placement of the residents (the nursing homes cannot meet their needs adequately, such as too heavy care for the staffing, exit seekers, aggressive).

Families and residents who will not heed warnings with regard to acceptable items that are brought into the facility, such as powders, unsafe furniture, electrical items and unauthorized food items.

Education and Training

Challenges related to education and training were described by participants in many sessions/focus groups, and by a few respondents to the survey. The issues described included a lack of training/education and/or a lack of knowledge and skills on specific topics (e.g., dealing with challenging behaviours, dementia, mental health, palliative care), barriers to participating in education and training opportunities (not hearing about available opportunities, lack of staff replacement to allow frontline workers to attend, financial barriers), and inconsistencies in the education/training provided to staff in different facilities or settings. Challenges related to poor skill level of staff newly graduating from educational programs were also discussed in a few sessions/focus groups.

Lack of knowledge and training about how to work safely in the community.

I feel very strongly that students who are graduating from health professions are not entering their respective fields competent in the performance of lower risk body movements or use of assistive equipment.

Untrained, unskilled staff.

Can't spare staff for training because unable to replace due to staffing shortages.

Insufficient training/education on violence in the workplace

Lack of budgets and time available to train employees.

Minimal opportunities to have education/training on up--to-date techniques or refreshers on patient handling.

Policy

Policies that present barriers to workplace health and safety were mentioned in many of the consultation sessions and focus groups, but were only mentioned by a very small number of survey respondents.

At the system level, consultation/focus group participants spoke about:

- The lack of public funding to support workplace health and safety and about funding cuts that affected health and safety.
- Improper placement of clients/patients/residents, due in part to pressures in the system (e.g., hospitals face pressure to discharge patients and organizations providing support [LTC, home care and community services] face pressure to accept clients without proper supports in place).
- Policies do not address the growing needs of clients/patients/residents (e.g., existing requirements for staffing levels that may not be sufficient to address the care needs).
- Licensing requirements that may not contribute to safety.
- The key performance indicators recently established in home care that do not sufficiently address worker health and safety.
- Existing legislation, regulations and licensing requirements that may not provide enough specific or detailed guidance to/requirements for organizations.

Internal policies at the organization level that may negatively impact safety were also discussed. For example, policies on travel time or breaks, how care is organized or delivered, etc. Inconsistency in policies that affect safety between organizations was described (i.e., one organization may not provide services due to safety issues, but another organization is willing to step in), as well as a lack of enforcement of existing policies.

A lack of data and information to inform policies and practices was also mentioned (e.g., lack of provincial information on the needs of LTC residents).

> *Lack of provincial standards for providing health care in a home environment.*
>
> *Government not funding sufficient workers to match the workload because they are not measuring the care needs of the LTC clientele*
>
> *Management not addressing staff concerns as a result of budget constraints, i.e., not purchasing resources that staff need.*
>
> *Lack of funding supports from DCS for staff training and resident resources.*
>
> *LTC may not be ready to receive a patient the hospital is pressured to move (e.g., an influenza causing widespread illness of residents and staff ratio down due to illness), yet the LTC is forced to accept the client placing further burden on staff and potentially placing client at risk.*

Accountability

About one-fifth of survey respondents, and participants in some sessions/focus groups described a lack of accountability for unsafe practices, on the part of the system (e.g., minimal inspection/enforcement by LAE, lack of follow up/investigation from WCB on claims), organizations (e.g., lack of follow up on incidents or to address reported safety hazards), at the individual employee level (e.g., lack of consequences for employees who do not follow safe practices), and for clients/patients/residents (lack of accountability for unsafe behaviour).

In every one of the work places I currently work and have worked in recent years, there has not been any enforcement/discipline related to these persistent higher risk practices (unless of course it was a blatant risk to clients or significant incident).

Management not dealing with staff who refuse to use safe practices after being taught proper procedure

No thorough investigation by employer's OH&S and the WCB when a worker has an injury.

Management not following through on reports or hiding safety issues instead of being transparent & honest.

Things go too long getting fixed after reported, even when JOHSC says it's a safety risk.

Our residents have no consequences to their behavior . . . because it is their home they can do whatever and say whatever they want.

Lack of consequences to the client/resident who injured the worker.

Leadership

In some focus groups/consultation sessions, and in a few responses to the survey, participants spoke about challenges related to leadership. Consultation participants described issues such as a lack of understanding on the part of management/leadership of the daily work of frontline staff; inability/unwillingness to address safety concerns; the large span of control of many supervisors/managers (i.e., many staff/facilities they supervise) which means having limited time to focus on or address worker health and safety issues; lack of knowledge/skills related to worker health and safety; inconsistency in following policies; and a lack of empowerment/ability to make changes or decisions that would improve worker health and safety.

Senior leaders who don't understand the hazards associated with the work that is being done.

Supervisors are not present in the home so have no idea of the day to day that happens and the verbal and sometimes physical abuse staff are forced to deal with on a regular basis.

No support from management when it comes to dealing with violent/aggressive behaviours.

Management seems to say they are working on solutions but as staff we are not seeing action.

Having an employer who does not take concerns seriously.

Management that is not focused or educated on these issues.

Supervisors are not trained in accident/incident investigation so incident reports are incomplete.

Occupational Health and Safety Management Systems

A few survey respondents and participants in some focus groups/consultation sessions described elements of the occupational health and safety management system that were inadequate. Participants spoke about a lack of support for return to work for injured workers (e.g., lack of awareness, not enough staff to support modified duties, etc.), risk assessments and/or incident investigations that are not conducted as they should be, and ineffective/weak JOHS Committees.

When risk assessments are not completed properly.

Our JOHSC does not have ample information and rarely receives information in a timely manner to look at incidents, much less trends in staff injuries.

JOHS committee has NO authority.

Communication and Information-Sharing

In some focus groups/consultation sessions and in a few surveys, participants discussed a lack of communication and information-sharing related to health and safety. This was mentioned within organizations (e.g., lack of communication between staff or between departments) and also in relation to sharing information about clients/patients/residents across settings/facilities. For example, clients may be moved into a LTC facility or sent to a home care agency without documentation or sharing information about their history (e.g., history of challenging behaviour). There are no electronic systems across the province to support sharing of information about clients/patients/residents.

> *The lack of information that is relayed to care providers before being sent into people's homes and that safety questions are incredibly brief and fail to address a large part of what makes an environment safe.*
>
> *I feel this starts from the initial visit with the care coordinator. We not only need to know about the client. We have to know about their surroundings.*
>
> *Lack of communication amongst workers.*
>
> *Dangers not disclosed by hospitals, care coordinators, patients and staff.*
>
> *No communication between frontline staff and management.*
>
> *. . . the team indicates that they are frequently not consulted when a new admission or change in resident condition requires an adjustment to their mobility.*
>
> *When certain patient behaviors are not charted by staff (aggressive, confused, impulsive, etc.).*

Opportunities and Supports

Considering the positive and negative influencing factors identified, participants in the consultation sessions and focus groups were asked to identify the best opportunities for improving workplace health and safety in their workplace as well as the supports needed to take advantage of these opportunities in Nova Scotia. Survey respondents were asked how their work/workplace could be made safer. Most of the opportunities and supports were not associated specifically with a particular setting (i.e., LTC vs. home care vs. small options homes, etc.), but if a specific setting was noted, this is described within the theme. The opportunities and supports in this section are described in order of the strength of response for each opportunity/support, i.e., those mentioned most frequently are presented first.

Staffing

Participants in most focus groups/consultation sessions and some respondents to the survey identified opportunities and supports related to staffing:

- There is a need to re-evaluate staffing models, requirements and skill mix based on the acuity and care needs of the patients/residents/clients being served. This might result in an increase in the number of staff, a change in the mix of staff, or increased access to specialized staff (e.g., occupational or physical therapists, staff with expertise in workplace health and safety). The need to ensure that organizations are not working short-staffed was also mentioned, in relation to frontline care providers as well as other types of staff such as maintenance or recreation staff.
- Support for staff is critical. The supports described included appropriate orientations for new staff, mentorship or one-on-one/peer-to-peer support, and training opportunities. Participants/respondents also emphasized the importance of supports for staff physical and mental health such as Employee Assistance Programs, addictions programs, encouraging staff to practice self-care, and de-stigmatizing mental health issues.
- Human resource needs for these sectors overall need to be addressed, i.e., ensuring that there is an adequate supply of appropriately trained staff (e.g., Continuing Care Assistants) to fill available positions. Addressing wage disparities for CCAs across the system could help to attract and retain quality care providers in all settings.
- Involve the Boards of Directors of individual organizations in safety issues – provide them with appropriate education and supports so that they understand their role.
- Ensure job expectations and roles are clear and incorporate consistent safety expectations and practices that are appropriate for each role.
- Encourage and support teamwork among staff.
- Use the scheduling system to ensure adequate break/rest and travel time (where applicable) are available.
- Coordinate safety messages/policies/practices for staff with those provided by unions.
- A few survey respondents also spoke about the need for staff to follow safe work practices (e.g., use protective equipment, dress appropriately, use proper body mechanics, etc.).

Correct mix of workers and enough care workers to match the workload and acuity of the residents.

Working with a full complement of staff and maintaining continuity of care with clients.

Increase the staffing FTE complement in homes based on footprint and design.

Review of funding model for staffing levels. It has been a number of years since the ratios have been set. The complexity of care that residents require, as well as the significant increase in needs related to comorbidities have left us short many times even when we are not.

Having better plans in place for coverage during planned and unplanned leave, having more timely replacement of staff who move out of continuing care.

A realistic and achievable work schedule.

Better block of work so we do not have to be available for a 12-hr. day and only getting approximately 6 hrs. of work due to split shifts.

It comes back to a team approach, everyone has to be on board.

Employees being mentors to others.

Everyone working together.

Pay workers a fair wage for what we do, so good employees do not leave for better working environments.

Having the proper staff to do the appropriate work (i.e., nursing for nursing, dietary for food handling, housekeeping for cleaning, laundry for laundry).

Management making their staff's mental health a higher priority.

Having workshops and an exercise program and gym provided for workers.

Mandatory & easily accessible programs (whether it is group or individual therapy sessions, regular debriefings with neutral party, ongoing and extended training to deal with aggressive & high/complex needs clients, etc.).

Training and Education

Training and education was mentioned in all consultation sessions/focus groups, and by some survey respondents as an opportunity to improve workplace health and safety. Participants/respondents spoke about the need for more training opportunities both before employment and for current employees, provided internally by organizations, as well as by external partners. Training/education opportunities should be provided regularly and should include supports to facilitate participation (e.g., provide staff replacement costs, or provide training online or locally), as well as follow up to ensure the skills learned are implemented. Specific topics/training sessions mentioned included PACE, P.I.E.C.E.S., GPA, safe lift and transfer, body mechanics, mental health, workplace violence/bullying, Low Arousal, non-violent crisis intervention, palliative care, and more general topics such as safety roles and responsibilities, WHMIS, fire safety, and CPR.

Participants/respondents mentioned the need to ensure training is consistent both between organizations and within organizations (e.g., all types of staff including managers participate in the same training); and to provide education/training to those that interact with/support the sector (e.g., OT/PT, physicians, care coordinators, etc.). It might also be helpful to share training opportunities across organizations (e.g., especially in more rural/remote areas).

More training for staff and on a more routine basis.

Ongoing employee training and up to date on best practices.

Educate and practice with staff on how to use panic buttons and how to intervene in a code white.

More mandatory education BEFORE people get into their workplace.

More training in body mechanics, proper lifting techniques. This training needs to be more hands on not just courses on the computer.

Accountability

Mechanisms to enhance accountability were identified by participants in most focus groups and consultation sessions, and by a few survey respondents as an opportunity to improve workplace health and safety. Accountability was described at multiple levels:

- At the organization/employer level, organizations should be held accountable for practices and policies that affect safety. This could be done through increased inspections by LAE; safety audits (e.g., conducted by an external organization like AWARE-NS); ensuring safety is reflected in licensing requirements; identifying organizations with high incident/injury rates and putting supports in place; linking key performance indicators (KPIs) in home care to safety; and participating in accreditation processes.
- At the organizational leadership level, managers/supervisors/senior leaders should be accountable to employees in reporting on/communicating and addressing safety issues (this is also discussed under the Leadership theme below).
- At the employee level, staff should be held accountable for following safety practices and policies (e.g., following policy consistently, using safety equipment as required). This could be done through performance management practices and appropriate disciplinary policies/actions where required. It was noted that employers should work with their union partners in regards to employee discipline.
- At the client/patient/resident level, there should be appropriate accountability in place for someone who harms workers (taking into account the mental capacity of the individual) and this should be clearly communicated with staff and others.

Ensure managers and supervisors are held accountable and responsible for good outcomes.

Have expectation of change of practice within LTC so there is follow through and consequences if poor practice is witnessed.

Everyone being held accountable for their actions- and it be part of their Performance Review.

Develop a management expectation to hold staff accountable when they do not follow recommended procedures.

Enforcement and Discipline – as much as I truly dislike saying that, I feel it is a component that is lacking. We have EDUCATION ++++ but that alone does NOT change behavior – we need other components (and I realize not just enforcement/discipline) but there has to be ACCOUNTABILITY built into our hiring practices and performance appraisals and ongoing work.

I feel that each client/family should be sent a letter initially and yearly reinforcing the rules, i.e., no smoking, pets away, clutter free work spaces, shoveling/plowing, back-up plans. I think that the people making the decisions to send me into a home should reinforce the rules better.

Data to Inform Improvement, Planning and Accountability

Consultation participants also spoke about the importance of systems to collect and track safety-related data as an important support to identifying and addressing safety issues. This data can then be used to inform planning and policy development, as well as to establish desired outcomes or targets related to workplace health and safety. For example, government could define a standardized, consistent tool that could be used to document safety concerns, incidents, and investigations.

Leadership

In most consultation sessions/focus groups, participants identified the importance of leadership for workplace safety. This was also discussed by a few survey respondents. The comments about leadership seemed to relate primarily to leadership at the organizational level, but government leadership was also mentioned. At the organizational level, leaders (i.e., managers, supervisors and/or senior leaders) should have the right knowledge and skills in relation to safety, and be engaged in safety issues and practices (e.g., clear communication and follow-up with staff, actively participating with staff in safe practices, have a visible presence in addressing safety issues, modelling safe behaviours, etc.).

In addition, participants highlighted the importance of leaders in government and at the organizational level having a clear understanding of the daily work and context of staff (e.g., pace of the work, complexity of clients, safety-related challenges, etc.). In one session, participants spoke about having senior leaders participate in front line care for a day to get a true sense of the daily work of frontline workers.

Supervisors need to be trained in incident/accident investigation and recommendations.

More engagement from management and executive members.

As a leader, I could be doing more safety walk abouts.

Ask staff to evaluate senior leaders' role in engaging staff and speaking about safety – engaging staff to provide feedback on senior leaders' commitment to safety via their (senior leaders) annual performance appraisal.

Management needs to be engaged in the outcomes and hold themselves and workers accountable to meet these outcomes for the health and well-being of the workers and of those we support.

Management needs to be pro-active in identifying risks before they become reality and taking measures to minimize or eliminate these risks.

Safety Culture and Employee Engagement

In most consultation sessions and focus groups, participants spoke about a culture of safety, both as an opportunity for change and a needed support. This was also mentioned by a few survey respondents. The workplace culture has to support safety by prioritizing worker safety (e.g., emphasizing the importance of completing a task safely, not just completing it); by reducing blame and promoting reporting of safety incidents/hazards/near misses; through frequent communication about safety issues and topics; and by ensuring that all staff understand that violence is not accepted. The importance of valuing and proactively engaging with workers was also noted. Staff should have opportunities to raise concerns or issues related to safety, and should be empowered to act on identified issues, as well as having management/leadership who will listen to and address concerns. Showing appreciation and respect for all staff was also mentioned. Changing an organization's culture may require supporting staff and management using behaviour change techniques.

Ask for feedback as to how we can accomplish this or do they see anything we can improve on. Engage the team.

It is imperative that there is a commitment to safety at all levels of the organization. Safety must remain in the forefront at all times.

OH&S cannot be a stand-alone program or a binder on a shelf. Without words and actions that demonstrate a value of people, it won't be sustained.

Visual and active safety campaign that reinforces key safety factors. Safety added to annual reviews.

Making safety a consideration in all decisions and integrate it into the fabric of the organization.

Engage staff – ask them this question: who is going to get hurt today and how?

Trust – staff needs to feel safe to report unsafe work practices.

When I express concerns either about an environment or client/family member, it should be taken seriously and addressed ASAP. Don't make me feel guilty or like I'm over reacting.

When employees feel their employers value them and care about their well-being on or off the job, safety will follow.

Communication

Communication was mentioned in many focus groups and consultation sessions and by a few survey respondents as an opportunity for improving workplace health and safety. Participants/respondents described the importance of having strong communication practices in place to proactively discuss and address safety issues and information. For example:

- When safety issues are identified, management should share this information and report back on the steps taken to address these issues.
- There should be clear communication between staff about patient/client/resident needs and safety issues. This communication should follow the individual if they move between settings, e.g., home care or hospital to LTC.

Mechanisms to support communication within an organization included regular team meetings and/or shorter "huddles" specific to addressing health and safety issues (e.g., huddle to brainstorm solutions for a specific situation or client). Communication tools such as videos and posters may also be useful, and technology can be used to facilitate communication as required (e.g., cell phones in the home care context).

Case conferences, electronic record systems, or other mechanisms to support communication and information-sharing across different settings in the system (e.g., hospitals, community facilities, community/home settings, etc.) are also important supports to share safety-related information about clients/patients/residents as they move through the system.

Information regarding client care needs to be conveyed well to the community worker.

Mindful, purposeful discussion about safety every single day, at every single meeting or discussion.

Hold round table meetings with different groups of staff to discuss safety. Smaller groups would be effective.

Continue to involve staff in discussions around safety i.e., huddles, audits, education.

Daily check-ins with staff: Is all the equipment working, were any of the residents aggressive, if so what did you do?

Updates to tell us that something was made safer if we reported it unsafe.

Having case conferences for difficult clients with staff to ensure uniformity in treatment and care and input from staff on best ways to provide care.

Making sure any and all changes regarding a client's person or home are made aware to supervisors so they can alert all employees.

Funding

Funding was mentioned as a required support in many consultation sessions and focus groups, and by a few survey respondents. Where detail was provided by participants/respondents, they mentioned that funding should be allocated to needs such as staffing, equipment, training/education for staff, and supports for patients/clients/residents (e.g., supports that could help to reduce challenging behaviours such as more recreation, access to specialized staff like PT/OT, etc.).

More support from the government for the resources... time... tools... and supports.

Funding [so that we are] able to staff the more aggressive people properly.

Funding for material and tools to make work safer and easier for staff, i.e., slider sheets, more slings, ceiling lifts.

More money for prevention activities and tools.

Nursing homes need a general increase in operating budget to put more staff on the floor and at the residents' bedside, and increase the physiotherapy team sizes to better work with the individual mobility needs of residents and staff.

Policy and Legislation

In many focus groups and consultation sessions and in a few survey responses, participants identified changes to policies or legislation as an opportunity to enhance safe and healthy workplaces. In particular, the need for consistent or harmonized policies (across the province, between organizations/settings) was identified, as was the importance of updating the Homes for Special Care (HSC) Act to better reflect the needs of clients/patients/residents who are receiving care now and support worker safety (in particular, revising staffing requirements and skill mix to reflect current complexity/acuity levels and associated needs). In one consultation session, participants spoke about the need for a mental health policy/strategy that would support both employees and patients/resident/clients. A few survey respondents and participants also mentioned the need to review the WCB's policy of accepting claims.

Having the department of health change the staffing per resident ratio.

More consistency across the province with respect to transfer/lift programs/techniques as well as bed mobility and in general client mobility/moving techniques.

Provincial standards for home support sector.

WCB take a harder line especially with those who have claim after claim.

Work Environment

Participants in some focus groups and consultation sessions, and about a fifth of survey respondents identified various aspects of the work environment that could be addressed to improve health and safety. These included:

- **Equipment:** More equipment such as hospital beds, lifts, slider sheets and other items is needed. Participants also spoke about the importance of ensuring available equipment was regularly inspected, maintained, and repaired/replaced as needed.
- **Facilities/Home Environments:** Facilities/homes should be properly maintained and new facilities should be designed with safety in mind and allow sufficient space to meet resident/client/patient needs. Issues such as clutter, spills, and air quality should be identified and addressed.
- **Security Systems:** Provide supports such as panic buttons, alarm systems, locked down facilities, or security guards where appropriate.

Having lift and transfer equipment for bedrooms, recreation areas and bathrooms/tub rooms. Laundry machines and carts that are back-friendly.

Lighter wheelchairs for lifting purposes when transferring into vehicles.

More bariatric equipment.

Carpets replaced with laminate flooring.

Increased space in patients' rooms.

Residents with dementia should have sufficient private space, i.e., private rooms.

Provide snow removal or a snowblower that staff can get it done quicker and get back inside.

Safety officer on duty at all times.

Having designated parking spaces for staff carrying heavy loads, supplies and charts.

Reduce clutter.

Have air quality tested on a regular basis.

House inspections. Ensure that the outside of the house is safe such as decks or walk ways if applicable.

Occupational Health and Safety Management Systems

In a few surveys and in some focus groups and consultation sessions, participants spoke about enhancements that could be made to occupational health and safety management systems that would contribute to improved workplace health and safety. These included:

- Employee incentives and recognition to support positive performance on health and safety (e.g., financial incentives for facilities that reduce their injury rates and/or invest in workplace health and safety; providing employees with a gift card when they report a near miss or hazard; and/or rewarding or publicly acknowledging/celebrating good safety practices).
- JOHS Committees that identify, investigate and report on safety incidents/near misses; help to identify risks and monitor trends; make recommendations to management to improve workplace health and safety; and help to inform and educate staff about health and safety.
- Safety practices such as use of cell phones/GPS and remote location plans help to address safety concerns.
- Policies that support health and safety (e.g., that address driving in poor weather, that support employee wellness, etc.).
- Organizations should have adequate support for return to work after an injury, including access to staff with expertise in claim management/return to work; supports for injured workers (e.g., physios, knowledgeable primary care providers, etc.); and an understanding and acknowledgement of the mental/psychological impact of a physical injury.
- Encourage reporting and investigation of hazards, incidents and near misses, including appropriate follow up on identified issues and communication back to staff about any changes as a result of the issue.
- Organizations could benefit from having a dedicated or designated safety lead, someone who is responsible for safety-related tasks (e.g., completing inspections and audits) and can act as a leader/champion in relation to workplace safety.

Strong, functional JOSH committees with dedicated senior leaders participating.

Stronger JOHSC committee to engage employees on a regular basis.

Policies to support staff health and wellness initiatives.

Storm day policy that is reflective of our job driving all day and not one suited to an office job.

A more detailed safety questionnaire should be asked prior to service with a follow up completed during first visit.

Proactively identifying risks and mitigating them before they become an issue.

Issuing cell phones to all staff who work alone in community in event of emergency.

GPS and safer travelling monitoring.

Investigate more thoroughly into what happened, how to prevent and change.

Establish safety teams and processes they can use to investigate reported safety risks so that issues can get the follow up they need in a timely manner.

Dedicated OHS person responsible to be able to initiate programs and follow through completing audits in real time when work is being completed.

Client/Patient/Resident Assessment and Placement

In some sessions and focus groups and in a few surveys, participants/respondents spoke about client/patient/resident assessment (to identify risks and needs) and proper placement as critical elements of addressing workplace health and safety. It is important to assess the needs of the client/patient/resident both when they first come in to the care setting and on an ongoing basis to identify changes in needs and safety risks/issues that may be present. This assessment of needs should inform the support required (e.g., staffing levels as discussed in the Staffing and Policy and Legislation sections) as well as where the individual is placed. Wherever the individual is placed, adequate supports need to be put in place to support the needs of the individual in their current setting (more supports may be required if the individual is in a setting that is not ideal as a result of capacity issues in the system), as well as to address safety issues for staff (e.g., plans for how to address aggressive behaviour).

Having appropriate housing to house clients in their best fit environment as opposed to being on wait lists for years for those places.

Ensure that those residents who are slated to move into nursing homes are appropriately placed. PT/OT assessments in the home.

Better assessments of violent residents prior to admission.

There should be a meeting of all disciplines inside and out before client discharged from hospital -- if client coming directly from community then this should happen before service from agency starts and there needs to be ongoing re-evaluation from community rehab.

When we communicate that a client's needs have changed, his/her ability to weight bear, changes in mobility etc., a supervisor of some kind needs to reassess the client ASAP.

A plan in place for aggressive parents or situations that are deemed frightening for staff.

Collaboration

In some focus groups and consultation sessions, participants spoke about the importance of collaboration and cooperation across all levels (from government leadership to frontline staff) to address health and safety issues. In particular, organizations within and across sectors should collaborate to share safety information and best practices (e.g., established policies, effective strategies for addressing a particular issue), resources (e.g., staff with particular expertise such as in RTW/injury management could be shared across organizations), and training opportunities. This collaboration could be done in person (e.g., face-to-face meetings) or using other mechanisms such as websites or email. In one session participants also spoke about collaborating through group purchasing.

Awareness

Participants in some consultation sessions and focus groups highlighted the importance of increasing awareness in relation to worker health and safety as both an opportunity and a support. This was most frequently described in relation to education and awareness for family members of the patient/client/resident about the role of the worker and how care is delivered, and the safety requirements, including explaining why certain policies/practices are in place. In one session, participants also said that increasing awareness among the public about the role of home care staff would be beneficial.

Health System/Service Delivery

Participants in a few focus groups/consultation sessions spoke about changes to the health system or service delivery approach more broadly as an opportunity to improve workplace health and safety. This included: creating a more integrated/less siloed approach to care; investing in more LTC beds/more home care hours; and changing the funding model so that it reflects the needs of individuals (i.e., funding that would be tied to the individual client/resident/patient).

Conclusion

This report presents the findings from the consultations conducted for the *Workplace Health and Safety Action Plan for the Health and Community Services Sectors*. These consultations gathered feedback from those working in or supporting organizations in the LTC, home care, and community services sectors, including frontline employees (direct care providers, housekeeping, dietary, maintenance, etc.), managers/supervisor, senior leaders, and others (e.g., union representatives, care coordinators, licensing staff, etc.). Participants in the consultation process identified many factors that support workplace health and safety, as well as those factors that present challenges for working safely. Participants also described many potential opportunities for improving workplace health and safety, as well as the supports needed to take advantage of these opportunities in Nova Scotia.

The findings from these consultations will be used to help inform the selection of actions for inclusion in the Action Plan.

Addendum: Family and Friend Caregiver Survey Findings

Summary

Family and friend caregivers help sick and injured people stay in their homes, or provide them with additional care and support in a facility setting. In order to inform the development of the Workplace Safety Action Plan for Nova Scotia's Health and Community Services Sectors and provide family and friend caregivers with an opportunity to share the things that impact both their own health and safety and that of paid care workers, a survey of family and friend caregivers was conducted. Almost 300 individuals completed the survey.

The survey findings suggest that family and friend caregivers do interact with paid care workers, are aware of the health and safety policies that apply to paid care workers, and generally feel comfortable discussing issues related to the worker's health and safety. The findings also indicate that family and friend caregivers are aware that homeowners have a responsibly to address issues that may increase the risk of injury for paid care workers, and have made changes to address safety concerns identified by paid care workers. Family and friend caregivers reported pressures on their own mental and physical health (e.g., increased stress, physical pain or discomfort as a result of giving care, etc.), which may have an impact on the health and safety of paid care workers as caregivers may be less able to address health and safety issues or assist paid care workers with providing care safely. Finally, survey respondents identified several actions that could help improve the health and safety of unpaid caregivers and paid care workers, including greater paid staff support for patients/clients/residents (clients); strong communication between paid workers and family/friend caregivers about safety and the care needs of the client; greater consistency in the paid care worker providing care; greater access to equipment/supplies/technology to help care for clients at home; more efficient scheduling of home care workers to minimize travel; more education for paid care workers; and greater supervision of paid workers.

Introduction and Purpose

In addition to the three consultation methods described earlier in this report (consultation sessions, focus groups and an online survey), a survey of family and friend caregivers was also carried out to help inform the development of the *Workplace Safety Action Plan for Nova Scotia's Health and Community Services Sectors*. The survey was launched later than the other consultation methods and the survey did not close in time to integrate the findings into the consultation report. The survey findings are therefore presented in this addendum.

Family and friend caregivers help sick and injured people stay in their homes, or provide them with additional care and support in a facility setting (i.e., nursing home, community services, hospital). Family and friend caregivers may perform care and support tasks that they have not been trained to do, and can be asked to assist paid care workers when they are present.

The purpose of the survey was to provide family and friend caregivers with an opportunity to share the things that impact both their own health and safety and that of paid care workers. Recognizing that family and friend caregivers give care and support in many different ways, not all issues that may be of concern to caregivers were covered in the survey. Only information/themes from the survey that are relevant to the health and safety of paid care workers are discussed in this addendum. However, all the survey responses were also provided to Caregivers Nova Scotia to help them identify areas or topics that they can incorporate into their programs and materials to better support the safety of family and friend caregivers.

Survey Methods

The family and friend caregiver survey was developed and promoted in partnership with Caregivers Nova Scotia. A copy of the survey is provided in Appendix B. The survey was made available online and in hard copy between March 8 and April 21, 2017. Hard copy surveys were collected and entered into the online survey system after the survey closed. Caregivers Nova Scotia was responsible for all promotion of the survey to family and friend caregivers in Nova Scotia.

Analysis

The survey was composed of primarily closed-ended questions, with only one open-ended question. Descriptive statistics were calculated for closed-ended questions on the survey. For these calculations, any missing responses were removed.

Information collected through the open-ended question on the survey was thematically analyzed using qualitative analysis software, Nvivo (version 10) (see Analysis section of this report for a description of the thematic analysis process). The strength of response for each theme is reflected in the order in which the themes are presented (those mentioned most frequently are presented first), and in the use of the descriptors “many”, “some” and “a few”. Direct quotations from survey respondents are also included to illustrate the themes.

Limitations and Considerations

- Survey responses were voluntary, i.e., no question was required to have a response before moving forward, so not all respondents answered every question. Percentages are calculated individually for each question/statement and are based on the number of unique respondents that answered that question/statement.
- Most respondents to this survey focused, understandably, on their own experiences and needs as family/friend caregivers, and not on the health and safety of paid care workers. There is therefore limited feedback relevant to paid care workers included in this analysis.

Findings

Survey Respondents

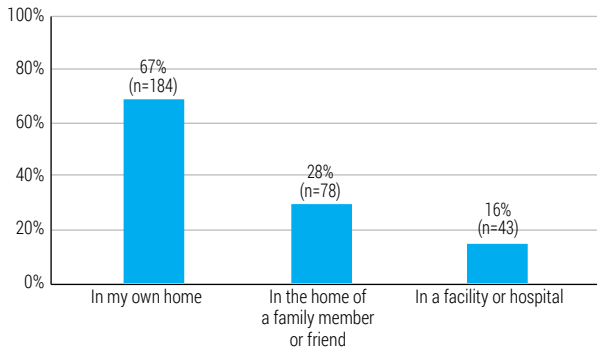
A total of 286 respondents completed the online survey. As seen in Figure 1, the majority of respondents provide care in their own home (67%, n=184 of 276) and/or someone else's home (28%, n=78 of 276). Only a few respondents provide care in a facility (nursing home or community services) or hospital (16%, n=43 of 276).

All respondents (100%, n=278 of 278) indicated that they provide care to an adult (16+), and only one respondent indicated they provide care to a child.

As seen in Figure 2, the majority of survey respondents assisted with general housekeeping tasks (92%, n=232 of 253) and cooking and meal preparation (87%, n=223 of 253), and about half of respondents also assisted with personal care such as bathing, toileting and dressing and/or treatment (e.g., injections, changing wound dressings, medications).

Survey respondents also indicated the restrictions/impairments of the person to whom they provide care (see Figure 3). The most common types of impairments/issues were those related to mood/memory/behaviours (70%, n=187 of 267), weakness/balance/coordination issues (69%, n=186 of 267), and difficulties standing from a chair/using stairs/getting in/out of a vehicle (64%, n=172 of 267). Only 10% (n=27 of 267) of respondents indicated that the person to whom they provided care was restricted to a bed.

Figure 1: Where Care is Provided (N=276)*



** Percentages do not sum to 100% as participants could select more than one option.*

Figure 2: Type of Physical Care/Support Provided (N=253)

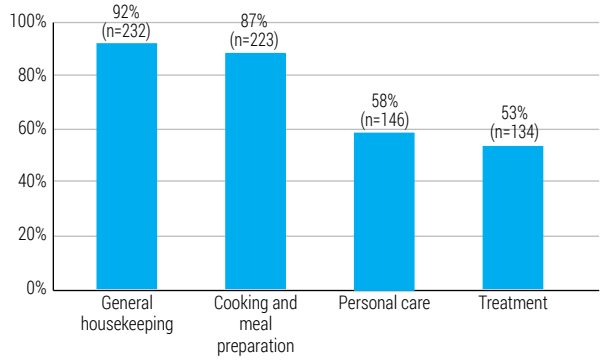
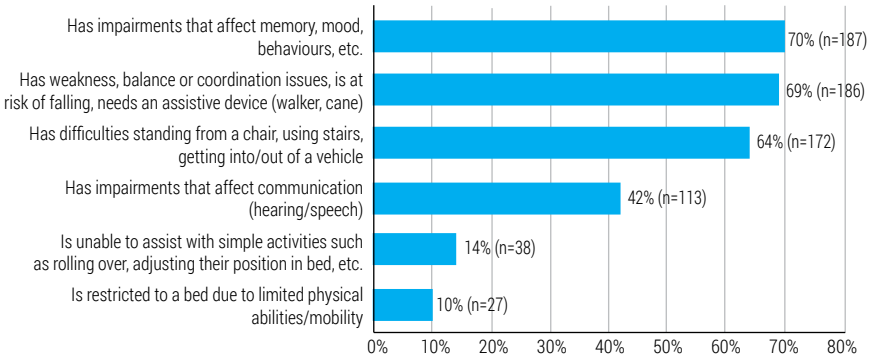


Figure 3: Restrictions/Impairments of the Person Receiving Care (N=267)*

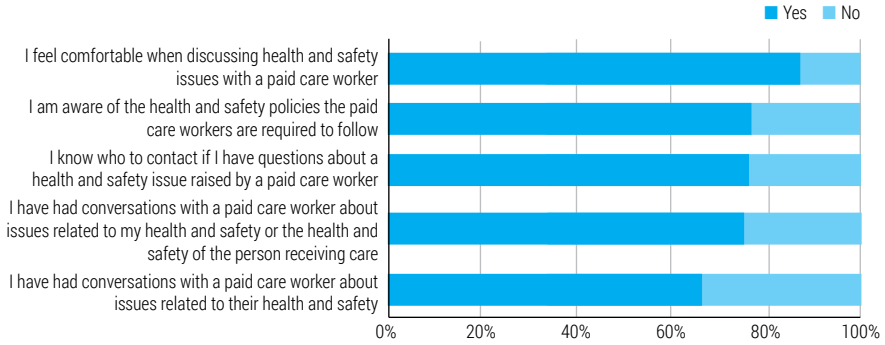


** Percentages do not sum to 100% as participants could select more than one option.*

Interaction with Paid Care Workers

Two-thirds of survey respondents (66%, n=189 of 286) reported that they have interacted with paid care workers who provide nursing or support services in their role as a family and friend caregiver. The majority of survey respondents indicated that they communicate well with paid care workers related to health and safety (see Figure 4). Most respondents said that they feel comfortable discussing health and safety issues with a paid care worker (87%, n=152 of 174), while approximately three-quarters indicated that they are aware of the health and safety policies the paid care workers are required to follow (77%, n=134 of 174); that they know who to contact if they have questions about a health and safety issue raised by a paid care worker (76%, n=128 of 168); and that they have had conversations with a paid care worker about issues related to their health and safety or the health and safety of the person receiving care (76%, n=133 of 176). About two-thirds said that they have had conversations with a paid care worker about issues related to the worker's health and safety (66%, n=115 of 173), meaning about a third of respondents had not discussed health and safety issues with a paid care worker.

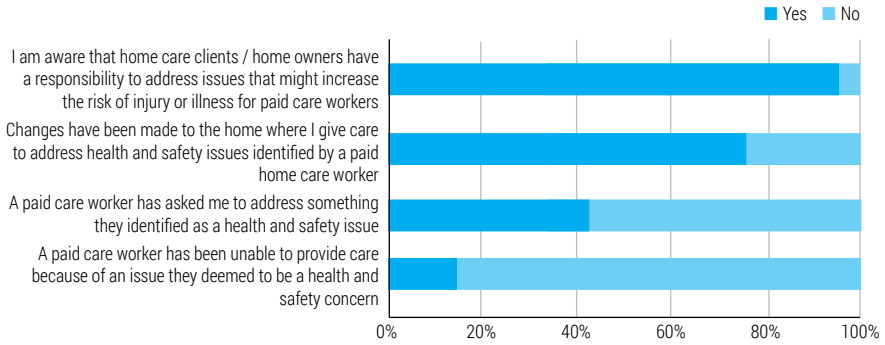
Figure 4: Communication with Paid Care Workers



The majority of survey respondents (82%, n=110 of 134) reported that paid care workers have access to the equipment they need to perform care tasks safely (e.g., lifts, adjustable beds, etc.).

As illustrated in Figure 5, most survey respondents (95%, n=159 of 167) said that they were aware that home care clients/home owners have a responsibility to address issues that might increase the risk of injury or illness for paid care workers (e.g., clutter, smoking, animals, firearms, etc.). While most respondents indicated that they have not been in a situation where a paid care worker has been unable to provide care because of an issue they deemed to be a health and safety concern (86%, n=134 of 156), almost half (42%, n=68 of 161) indicated they have been asked to address something that a paid care worker identified as a health and safety issue, and three-quarters (75%, n=100 of 133) said that changes have been made to the home where they give care to address health and safety issues identified by a paid home care worker.

Figure 5: Identifying and Addressing Issues Related to Health and Safety



Demands on Family & Friend Caregivers

The survey asked respondents to comment on the physical and psychological demands of the care they provide. The physical and mental health of unpaid caregivers may have an impact on the health and safety of paid care workers as caregivers who are tired, stressed and/or physically injured may be less able to address health and safety issues or assist paid care workers with providing care safely. Roughly a third of caregiver survey respondents agreed or strongly agreed that the tasks they perform while giving care put them at an increased risk of physical injury or illness (41%, n=107 of 264); that they have experienced physical pain or discomfort as a result of giving care (36%, n=94 of 259); and that the physical demands required to move, adjust, re-position, or transfer the person they are caring for are high (29%, n=75 of 260). Eighty percent of respondents (n=213 of 265) agreed or strongly agreed that they have experienced increased levels of stress due to the care they give.

Supports to Improve Health and Safety for Paid Care Workers

Survey respondents were asked to describe what they think is needed to help improve the health and safety of all unpaid caregivers and paid care workers in Nova Scotia. The information related to unpaid caregivers is outside the scope of the work of the Action Plan and is therefore not included in this report (information was provided to Caregivers Nova Scotia for their use). Of the approximately 190 survey respondents who answered this question on the survey, only a quarter referenced paid care workers specifically. These comments centred around the following themes (the themes mentioned most frequently are presented first):

- Some respondents suggested that **greater staff support** should be provided (both for home care and for facility-based care) to patients/clients/residents (clients) as this will alleviate the burden on both paid care workers and unpaid caregivers.

> *In certain instances, there should be two persons to move the patient, etc. In the nursing homes, no one worker moves a patient. Why should the personal caregiver?*
>
> *Ratio of caregiver to patient needs to be improved, especially for patients with cognitive impairment.*
>
> *I feel we need a lot more paid caregivers in place. The need continues to rise.*

- A few respondents emphasized the importance of paid workers **communicating with the family/ friend caregivers** about safety and the care needs of the client.

> *I would like to see more communication between the (unpaid) caregiver/individuals and other care providers. Education, communication, and clear goals would help all involved.*
>
> *Communication about safety from caregivers and their employer pertaining to safety for the client and the paid and unpaid caregivers.*
>
> *Paid caregivers need to thoroughly explain what the rules are for providing services and to ensure that the rules are understood.*

- A few respondents discussed how **greater consistency in the paid care worker** providing care would ensure they know the client's needs and limitations, and increase the level of trust the unpaid caregiver has in the paid worker.

> *[Need] access to direct caregiving help such that there isn't a different person at the door each time.*
>
> *Consistent care would be better. The staff change and there is little if any consistency. They don't appear to have read the patient's file. We keep starting at step one.*
>
> *It is also helpful to have one or two paid homecare workers rather that someone new each visit.*

- A few respondents spoke about the need for access to **equipment/supplies/technology** to help care for clients at home. While this was discussed mainly in relation to the needs of the unpaid caregivers, having relevant safety equipment in place (e.g., lifts, hospital beds) would also support safety for paid care workers.

> *Assistive equipment, e.g. hospital beds, lifts, incontinent products are very expensive to rent or buy . . . more people could be cared for at home if equipment was more accessible and affordable.*
>
> *Access to technology and adaptive equipment to assist caregivers in their roles. Contact information on how to apply or where to get equipment i.e., ramps/rails/bars, etc. for the infirmed.*
>
> *How/where to access aids such as lifts, etc. . . . safety aids available for house to keep client safe when you're not present, e.g., mat that sounds alarm when they exit house.*

- A few respondents indicated that **scheduling of home care workers** should be reviewed to make it more efficient and free up time to provide more care. Ensuring that paid care workers arrive on time was also mentioned.

> *Scheduling of these home care workers should be carefully reviewed. Why does a care worker from Ship Harbour travel to Chezzetcook to assist a Senior then back to Jeddore for another senior then back to Musquodoboit Harbour and finally back to Ship Harbour - Very poor scheduling. Care workers should be assigned seniors in their areas eliminating travel times and freeing up more time to spend with their clients.*
>
> *Having paid workers arrive on time.*

- A few respondents discussed the importance of **education for paid care workers** on topics related to providing care, and particularly noted that paid workers should be educated about the role and needs of the unpaid family/friend caregivers.

> *The more information a caregiver has about the person's disease or health situation, the better they can do their job, paid or unpaid. The paid carer should always be upgrading their training . . .*
>
> *For paid caregivers, it's very important that they receive education on the stresses faced by unpaid caregivers.*

- A few respondents mentioned that **greater supervision** of paid care workers was needed.

> *Care Coordinators . . . need to check-in more often to ensure the paid caregivers are doing their jobs properly.*

Appendix A: Stakeholder Survey

February 3, 2017 – FINAL

Stakeholder Survey

Background

Nova Scotia's health care and community services sectors represent the province's largest employer group and play a critical role in supporting and enhancing the health and well-being of all Nova Scotians. These sectors, like publicly funded health and community services in many jurisdictions, are challenged by the high cost of service delivery, increasing demands, and a high rate of work-related injury and illness. In Nova Scotia, the health and community services sectors have the highest rates of injury. Nova Scotia needs its care workers healthy, working and on the job.

Because of the size of the health and community services sectors in Nova Scotia, the high rate of work-related injuries and illnesses that could be prevented, and the impact of these injuries and illnesses on quality of care, stakeholders have come together to develop a ***Workplace Safety Action Plan for Nova Scotia's Health and Community Services Sectors.*** The Action Plan will focus on publicly-funded home care, long term care and community services.

Purpose

The purpose of this survey is to gather input from those working in the home care, long term care and community services sectors in Nova Scotia on the best opportunities and supports needed for improving workplace health and safety in your work setting.

Who Should Complete this Survey?

Anyone who works in home care, long-term care, or community services in Nova Scotia can complete this survey. Your participation in the survey is voluntary. It will take approximately 10 minutes to complete.

How to Complete the Survey

You can complete the survey either in hard copy or online. If you are completing a paper-based survey, please return the survey to AWARE-NS, 201 Brownlow Avenue, Unit 1 Dartmouth, NS B3B 1W2 or by fax **902-832-3445**.

You can also go to **http://24.selectsurvey.net/researchpowerinc/ActionPlan** to complete the survey online.

Confidentiality

There are no right or wrong answers, and you are free to skip any questions you do not wish to answer. Your responses are confidential. Do not write any personal information, such as your name, anywhere on the survey. The survey data will be stored securely on a password protected server, and analysis of the survey data is conducted by an external consultant (Research Power Inc.). By completing the survey, you indicate that you have reviewed the information provided above and give your consent to participate.

Thank you for your time and helping us to understand workplace health and safety in the health and community services sectors in Nova Scotia.

SECTION 1

Factors that Affect Workplace Health and Safety

1. In your view, what makes your work/workplace **safe**?

2. In your view, what makes your work/workplace **unsafe**?

SECTION 2

Actions to Improve Workplace Health and Safety

1. How could your work/workplace be **made safer**?

SECTION 3
Demographic Information

1. I work in (select all that apply):

   - ☐ Home Care
   - ☐ Long-Term Care Home
   - ☐ Residential Care Facility
   - ☐ Hospital
   - ☐ Small Options / Group Home
   - ☐ Adult Residential Centre / Regional Rehabilitation Centre
   - ☐ Social Enterprise / Adult Service Centre Programs
   - ☐ Other, please describe: _____

2. I am a (select one):

   - ☐ Direct care provider
   - ☐ Staff other than care provider (e.g., maintenance, housekeeping, etc.)
   - ☐ Manager or Supervisor
   - ☐ Senior leader (e.g., CEO, Administrator, etc.)
   - ☐ Other role (e.g., Union representative, Care Coordinator)

3. I provide services in/work in (select all that apply):

   - ☐ North – *East Hants and Colchester, Cumberland and Pictou counties.*
   - ☐ West – *Yarmouth, Shelburne, Digby, Queens, Annapolis, Lunenburg and Kings counties.*
   - ☐ East – *Guysborough, Antigonish, Richmond, Inverness, Victoria and Cape Breton counties.*
   - ☐ Central – *Halifax County and West Hants.*
   - ☐ Provincial/ Other – *Work in or responsible for more than one area*

4. I have filed a claim with WCB Nova Scotia as a result of a work-related injury or illness.

   ☐ Yes ☐ No

Thank you for taking the time to complete this survey.

Appendix B: Family and Friend Caregiver Survey

Stakeholder Survey
Family and Friend Caregivers

Background

The health care and community services sectors represent the province's largest employer group and play a critical role in supporting and enhancing the health and well-being of all Nova Scotians. These sectors are challenged by a high rate of work-related injury and illness, and have the highest rates of injury. Nova Scotia needs its care workers healthy, working, and on the job.

Work is currently underway to create a five-year ***Workplace Safety Action Plan for Nova Scotia's Health and Community Services Sectors***. Due to the high rate of work-related injury experienced by home care workers, home care and home support is a major focus of the work.

Purpose

Family and friend caregivers help sick and injured people stay in their homes, helping to give them a safe, comfortable, and familiar environment. They also may perform care and support tasks that they have not been trained to do, and can be asked to assist paid workers when they are present.

This survey is designed to provide you, the family and friends who lovingly give care every day, with an opportunity to share the things that impact the health and safety of both family and friend caregivers, and of paid care workers. Recognizing that family and friend caregivers provide care and support in many different ways, not all will be covered or mentioned in this survey.

What will we do with the survey results?

The survey results will be helpful to us when creating the ***Action Plan*** and enhancing the health and safety of paid care workers. They will also help Caregivers Nova Scotia to identify areas or topics that they can incorporate into their programs and materials to better support the safety of family and friend caregivers. The results will help to identify where training and awareness programs that are developed for paid care workers can be adapted and delivered by Caregivers Nova Scotia.

Who should complete this survey?

This survey is intended for family and friend caregivers, those who are not paid to give care or support to sick or injured people in a private home, or to improve their quality of life in a hospital, long-term care, or community services facility.

Your participation in the survey is voluntary. **It will take approximately 10 to 15 minutes to complete.**

Confidentiality

There are no right or wrong answers, and you are free to skip any questions you do not wish to answer. Your responses are confidential. Do not write any personal information, such as your name, anywhere on the survey. The survey data will be stored securely on a password protected server, and analysis of the survey data is conducted by an external consultant (Research Power Inc.). By completing the survey, you indicate that you have reviewed the information provided above and give your consent to participate.

Thank you for your time and helping us to understand issues that impact the health and safety of caregivers in Nova Scotia.

March 2, 2017

SECTION 1
Demographic Information

1. I give care/support (check all that apply):

- ☐ In my own home
- ☐ In the home of a family member or friend
- ☐ In a facility (Nursing Home, Community Services) or hospital

2. I give care/support to (check all that apply):

- ☐ An adult
- ☐ A child (<16 years old)

3. The physical care/support I give includes (check all that apply):

- ☐ General housekeeping (cleaning, vacuuming, laundry)
- ☐ Cooking and meal preparation
- ☐ Personal care (bathing, toileting, dressing)
- ☐ Treatment (injections, changing dressings, medications)

4. The person I am caring for (check all that apply):

- ☐ Is restricted to a bed due to limited physical abilities/mobility
- ☐ Has weakness, balance or coordination issues, is at risk of falling, needs an assistive device (walker, cane)
- ☐ Has impairments that affect communication (hearing/speech)
- ☐ Has difficulties standing from a chair, using stairs, getting into/out of a vehicle
- ☐ Has impairments that affect memory, mood, behaviours, etc.
- ☐ Is unable to assist with simple activities such as rolling over, adjusting their position in bed, etc.

SECTION 2

Health and safety related interactions with paid care workers

5. In my role as a family and friend caregiver, I have interacted with paid care workers who provide nursing or support services

☐ Yes ☐ No

If Yes, please answer the following questions:

		Yes	No	NA / Don't know
a)	I am aware of the health and safety policies the paid care workers are required to follow	☐	☐	☐
b)	I have had conversations with a paid care worker about issues related to their health and safety	☐	☐	☐
c)	I have had conversations with a paid care worker about issues related to my health and safety or the health and safety of the person receiving care	☐	☐	☐
d)	I feel comfortable when discussing health and safety issues with a paid care worker	☐	☐	☐
e)	Paid care workers have access to the equipment they need to perform care tasks safely (e.g. lifts, adjustable beds, etc.)	☐	☐	☐
f)	I know who to contact if I have questions about a health and safety issue raised by a paid care worker	☐	☐	☐
g)	A paid care worker has asked me to address something they identified as a health and safety issue (e.g., put a pet away, clear snow off steps, move obstacles, etc.)	☐	☐	☐
h)	A paid care worker has been unable to provide care because of an issue they deemed to be a health and safety concern	☐	☐	☐
i)	I am aware that home care clients/home owners have a responsibility to address issues that might increase the risk of injury or illness for paid care workers (e.g., clutter, smoking, animals, firearms, etc.)	☐	☐	☐
j)	Changes have been made to the home where I give care to address health and safety issues identified by a paid home care worker (e.g., wall bars in the bathroom, anti-slip mats, etc.)	☐	☐	☐

6. For each of the statements below, please indicate how frequently this has occurred (Sometimes = less than 50% of the time; Often = more than 50% of the time):

		Never	Sometimes	Often
a)	I am asked to assist a paid care worker to provide care	☐	☐	☐
b)	When I assist a paid care worker, they explain to me the safe way to provide that assistance (Note: skip this question if you've never assisted a paid care worker)	☐	☐	☐

7. The statements below are related to your perception of the physical demands required for the care you give. For each statement, please indicate your level of agreement, with 1 being strong disagreement and 5 being strong agreement.

		Strongly Disagree 1	2	3	4	Strongly Agree 5
a)	The tasks I perform while giving care put me at an increased risk of physical injury or illness	☐	☐	☐	☐	☐
b)	The physical demands required to move, adjust, re-position, or transfer the person I am caring for are high	☐	☐	☐	☐	☐
c)	I have experienced physical pain or discomfort as a result of giving care	☐	☐	☐	☐	☐
d)	I needed to seek medical attention for an injury I received while giving care	☐	☐	☐	☐	☐
e)	I have experienced increased levels of stress due to the care I give	☐	☐	☐	☐	☐
f)	The tasks I perform are more difficult because there are obstacles or clutter that get in the way					

8. The statements below are related to the supports to give care safely. For each statement, please indicate your level of agreement, with 1 being strong disagreement and 5 being strong agreement.

		Strongly Disagree 1	2	3	4	Strongly Agree 5
a)	I have all the information I need to reduce my risk of injury while I am giving care	☐	☐	☐	☐	☐
b)	I have access to all the equipment I need to ensure that I can give care safely	☐	☐	☐	☐	☐
c)	I would benefit from additional education and training on how to safely perform many of the care tasks I currently give	☐	☐	☐	☐	☐

SECTION 3

Actions to improve caregiver health and safety

9. **Reflecting on the statements in the previous questions about the factors that affect caregiver health and safety either positively or negatively, please tell us what, if anything, you think is needed to help improve the health and safety of all unpaid caregivers, and paid care workers, in Nova Scotia.**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