WORKERS COMPENSATION BOARD OF MANITOBA

RESEARCH & WORKPLACE INNOVATION PROGRAM

Engaging an Organization in the Prevention of Work Related Injuries

Develop and utilize a visual display to support an injury prevention program to help minimize work related injuries for healthcare workers.

Researched and Developed by

Hôpital St-Boniface Hospital

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ENGAGING AN ORGANIZATION IN THE PREVENTION OF WORK RELATED INJURIES

ACKNOWLEDGMENT

The *Engaging an Organization in the Prevention of Work Related Injuries* project was supported by a grant from the Research and Workplace Innovation Program of the Workers Compensation Board of Manitoba.

St. Boniface Hospital acknowledges the financial support of the Workers Compensation Board of Manitoba through the Research and Workplace Innovation Program in the preparation of this project. However, the content of the report and/or the resource(s) is the sole responsibility of St. Boniface Hospital and the views expressed in it are those of the authors.

INTRODUCTION

St. Boniface Hospital utilizes an Occupational Health & Safety Incident Tracker system which is an electronic system that allows any employee to report incidents, illnesses or near misses they may experience while working at St. Boniface Hospital. This system's data is utilized to populate a visual display of injuries for all employee incidents in the hospital. The visual display depicts the locations where incidents have occurred, incidents which resulted in time lost from work as well as the most affected body part as a result of the incident. This then offers St. Boniface Hospital a unique way to identify any trends or clusters of incidents occurring throughout the hospital.

After utilizing the visual display for a time period, St. Boniface Hospital identified the need to evaluate the display in its current state to determine if any enhancements could be made. It was determined that the visual display was a great visual aid for reviewing incidents occurring throughout the hospital, however, we needed to enhance the utilization of the data collected in to prevent future injuries. It was determined the visual display needed to have standard work developed to outline roles and responsibilities as they relate to the display, as well as an identification of what the visual display's purpose would be and what actions would it drive.

The project utilized focus groups to gather information from employees at all levels within the organization to determine the best location for the display throughout the hospital as well as key details related to the development of the standard work.

Project Summary

St. Boniface Hospital currently has an effective electronic incident management system which is readily available for all employees to report an incident, illness or near miss. Employees are encouraged to report incidents. On an annual basis, approximately 900 incidents are reported into the Incident Tracker. Reported incidents are then responded to by managers and involves a thorough investigation; identification of root causes; and implementation of corrective actions (short and long term) to eliminate and/or minimize risks for employees.

The visual display of injuries was initially located in the Human Resources Department at St. Boniface Hospital and was limited in audience to executives, directors, Human Resources and Occupational Health & Safety employees. This project would determine how the visual display could be shared with all employees working within the hospital. Initially the display was utilized by executives and directors as a quick reference for where incidents were occurring and the body parts affected by these incidents at St. Boniface Hospital. By seeing their employees injured in other areas of the hospital, and seeing the clusters of incidents, the executive team were able to question what was going on, and better understand themes that presented themselves. For the visual display on this large a scale, colour coded dots were assigned to each executive/director group so they could get a sense of staff injuries at a glance.

The project was developed to involve directors and managers with detailed standard work processes for the visual display of injuries. Front line employees were involved in the project as they were the focus of improving safety metrics and measurable outcomes.

The project utilized focus groups to assist with gathering baseline data regarding what front line staff, managers and directors felt would be valuable information for the visual display of injuries. These focus groups also looked at gathering information regarding what the current state of health and safety communication was at St. Boniface Hospital and views from staff regarding best ways to improve identified communication gaps.

Following the completion of the focus groups, standard work processes for managers and directors were developed to outline responsibilities for upkeep of the display as well as injury prevention communication plans. These standard work processes were then piloted in 3 areas of the hospital (one patient care area, and two support services area) to determine their effectiveness at reducing work related injuries and illnesses, as well as improved injury prevention communication with employees.

Once an incident is reported in the Incident Tracking System, the system sends a notification to the employee's manager and Occupational Health & Safety that an incident is pending review. The manager will meet with the employee and review the details of the incident, and look for specific information regarding what happened, when it happened, and where it happened. From there managers would investigate further using the 5 Whys methodology. Working closely with Occupational Health & Safety, managers are to determine the root cause of the incident(s) and recommend immediate interim corrective action while developing plans for long term solutions. This could involve working closely with the Musculoskeletal Injury Prevention members to implement best practices or develop systems to reduce musculoskeletal injuries (examples such as repetitive strain, lift and transfers, push and pulls, etc.) or working alongside the Health & Safety members to determine solutions for more environmental risks (examples such as proper disposal of bodily fluids, dealing with sharp objects, to working in confined spaces, etc.).

OVERVIEW OF PROJECT

Patient Food Services (Support Services)

Implementation of Pilot Project

St. Boniface Hospital has been gathering data regarding incidents throughout the hospital and discovered that the Patient Food Services area was among the highest in reported incidents, ranging from near misses to injuries resulting in time loss claims. As the years progressed the amount of incidents was on a rise.

Below is a summary of the data that was collected:

- April 1, 2014 to March 31, 2015: a total of 55 reported incidents
- April 1, 2015 to March 31, 2016: a total of 57 reported incidents
- April 1, 2016 to March 31, 2017: a total of 79 reported incidents
- April 1, 2017 to March 31, 2018: a total of 65 reported incidents
- April 1, 2018 to January 16, 2019: a total of 46 reported incidents

As the incidents were increasing there was a need to dive deeper into the root cause of these incidents. It became evident that heat exposure was a theme that resulted with injuries occurring more on the hands and arms.

Despite the development and implementation of safe work procedures, personal protective equipment and training related to burn prevention, incidents resulting from heat exposure continued to occur. There was growing concern that employees of this department were experiencing an increased amount of injuries. It was important for the hospital to assess the situation and determine strategies on how to work together to ensure a safe workplace. If an employee was absent from work due to an injury it posed a concern that other employees had increased workloads, which could result in working faster and then lead to fatigue which was a risk to their safety. Employees suffering from work related injuries not only affect their work life, but their home life as well. This could have significant physiological impacts and affect their ability to return to work.

The pilot project was implemented in March of 2017. The purpose was to communicate and drive behaviours related to incident management, implementation of corrective actions, and follow through. With these improvement activities, the Patient Food Services area saw a corresponding decrease in incidents related to heat exposure on the tray line and reoccurrences, as well as an increase in safety awareness amongst employees.

The use of a visual display of injuries and the practice of standard work was introduced for a period of ten (10) weeks. Standard work consisted of conversations held at the daily team huddles to review any incidents that had occurred. It was important to create awareness amongst the team of what was happening, and the use of the visual display was a key element in the success of the conversations as employees could see what was happening. Every meeting involved a review of any corrective actions the manager and supervisors could do to immediately to improve safety and mitigate risk, asking employees questions regarding any concerns related to heat exposure, and exploring if employees had all the personal protective equipment required to prevent burns. A series of standardized questions was developed and asked at every meeting. Recognition was

encouraged to promote working safely and using proper personal protective equipment. Employees were provided with opportunities to identify unsafe work behaviours and be a part of the problem solving.

Through gap analysis, it was identified that there were concerns to identify root cause and provide corrective action for incidents as follow up was not conducted in a timely fashion. There was no consistent sharing of department specific incident information, nor shared risks or what corrective action had taken place.

It was also identified that employees were inconsistently using their personal protective equipment, and although safe work procedures had identified the use of gauntlet gloves, they were not always readily available for employees to use and the gloves did not work well for some employees, i.e. sizing issues and weight of gloves.

Outcome from Pilot Project

From the results of the gap analysis, the management team was able to develop strategies to improve overall awareness of incidents and minimized risk in the area.

The manager had purchased a variety of different heat resistant gloves and heat resistant wrist guards for all the employees to sample. All employees would rotate in trialing the samples and would provide feedback as to whether or not there were pros and cons to the equipment. They would have team discussions regarding the samples, and then determined as a team what would make the most sense for the employees to use and to ensure there was enough supply. It was the use of the visual display that helped identify the concerns around the personal protective equipment.

It was not uncommon for a manager to follow up with an employee, post incident, anywhere between 20-30 days. This was not an effective approach as employees may not recall the full details of an incident; it could be viewed as not showing concern for the employees' wellbeing; often it was too late to address the risk and prevent the incident from reoccurring.

The manager of Patient Food Services implemented a system that held her accountable for quicker follow ups post incident, with a goal of reaching the employee(s) within seven (7) working days. A graph was designed to showcase the amount of time that lapsed between incident and follow up. This graph was visible for all staff in that area to see. Employees were encouraged to bring up any concerns about lag time, but most often it was a proactive approach and follow ups were occurring within7 days, sometimes sooner. The manager also committed to reaching out to the employees and followed up with them post injury by phoning them at home after their work shift to determine that all was well and to obtain the details of the incident so she could start looking at it on a larger scale.

Implementing the visual display allowed for the unit to see just how many incidents were being reported. Prior to the project, incidents were not spoken about in team huddles. Many were unaware of how many incidents were taking place and that others were experiencing the same type of injury. It was a gateway for the team to come together and brainstorm ideas on how to reduce risk, especially in regards to heat related incidents. Group discussions took place to determine some causes that were contributing to these incidents. Employees brought to light that some injuries resulted from being distracted while talking during specific tasks requiring extra attention and focus. The employees themselves proposed a solution that they were not to talk while completing that particular task on the tray line. The proposed solution was tested during this 10 week period, and it is believed to have contributed to reducing some of the injuries.

Results & Evaluation of Pilot Project

As a result of the implementation of the visual display, awareness has increased regarding the types of injuries occurring and their causes. The efforts throughout the pilot project resulted in an 8% reduction in incidents.

Employees were observed utilizing the proper safe work procedures. When circumstances prevented the use of safe work procedures, employees utilized safe countermeasures to minimize the risk of injury. For example, if someone was carrying a pot full of hot liquid and someone was mopping up a spill they may not be looking up, which would prevent them from seeing the person carrying the hot pot. The employee carrying the pot would said “HOT POT” loudly to get the attention of the person mopping to create awareness versus trying to quietly maneuver around them. Noise levels in the kitchen were another contributing factor to injuries related to heat exposure. When employees engaged in loud and lengthy conversation they could not hear the person announce that they were carrying a hot item. Often when employees were working on the tray line they would have conversations with one another which often created a louder environment and cause increased distraction. The tray line operates 3 times a day which presents multiple risks on a daily basis. When the employees were aware of where and when the injuries were occurring, they came up with the idea of avoiding unnecessary conversations while working the tray line. This allowed employees to be focused on their tasks and to be aware of those employees carrying pots with hot liquids in them.

The manager and supervisors continue to communicate weekly with their employees regarding incidents and near misses. This identifies the hazards that employees need to be aware of and what corrective action is taking place to minimize the hazard. They also follow through with implementing corrective actions after an incident and monitor the implementation to ensure they are in fact minimizing or eliminating the risk in order to keep employees safe.

Between April 1, 2017, and September 14, 2017, there were nine (9) incidents related to heat exposure. Patient Food Services celebrated the successes of the safe work done by the employees, and also reviewed why the other months had incidents. It was determined that staff turnover was a factor related to incidents that were occurring as employees were rushing to keep up with the demands of the position. Although new employees received an orientation there was a sense that they had to work quickly to help, but this increased the risk of injury. The management team has reassured the staff that their safety is a priority and safe practices should always be followed. Management was also able to fill positions and redeveloped the orientation plan to include more conversations about safe work and injury prevention.

Housekeeping & Laundry (Support Services)

Implementation of Pilot Project

Housekeeping and Laundry Services were not originally part of the pilot project. However, when reviewing the data we noticed that incidents were on the rise, so we decided to include it in the pilot project. Similar to the pilot in the Patient Food Services area we noticed a spike in reporting once we launched the visual display. Below is a summary of the data that was collected:

- April 1, 2015 to March 31, 2016: a total of 48 reported incidents
- April 1, 2016 to March 31, 2017: a total of 74 reported incidents
- April 1, 2017 to March 31, 2018: a total of 64 reported incidents
- April 1, 2018 to January 16, 2019: a total of 82 reported incidents

Upon further investigation it was determined that there were three (3) types of causes that were being reported:

1) Push/Pulling,
2) Struck/Bump/Banged/Rubbed/Abraded/Hit by,
3) Lifting/Lowering

Incidents related to the above causes were trending upwards. Despite having safe work procedures (SWPs) and training related to proper body mechanics, there seems to be a disconnect between what has been provided to the employees and why injuries in this area were occurring.

The pilot was introduced to the manager on September 18, 2018. The purpose was to communicate and drive behaviours related to incident management, implementation of corrective actions, and follow through. The use of the visual display would create awareness amongst the team and open the door for discussions around injury prevention, as well as decrease the number of injuries.

The use of a visual display of injuries and the practice of Standard Work was introduced for a period of ten to twelve weeks. Categories identified on the display consisted of the location the incident took place, a body map to identify what was injured, and the cause of the incident.

Standard work was determined and implemented in the conversations held at the daily team huddles, which commenced on November 1, 2018, to review any incidents that had occurred. It was important to create awareness amongst the team and use the visual display as a key element to begin conversations with staff to understand what was happening, and that others were also experiencing injuries. Every meeting involved a review of any corrective actions manager and supervisors could do immediately to improve safety and mitigate risk. Employees were provided opportunities to identify any unsafe work environments and problem solve improvements. It was a chance to review the push/pull tasks related to the beds in the patients' rooms and discuss opportunities for improving safe work practices. It also provided an opportunity to review the safe work procedures and ensured all employees had appropriate training regarding proper body mechanics. This was particularly important for repetitive work done in areas requiring objects to be moved frequently to ensure effective cleaning of the area.

St. Boniface Hospital offers an "In-Charge Persons Safety Responsibilities and the Incident Tracker" training. This training allows the management team to have a better understanding on how incidents are completed, and provides training on how to conduct a root cause analysis by using the 5 Whys methodology.

Through gap analysis, it was identified that employees were rushing to complete tasks, there was a lack of awareness regarding their surroundings, employees were inconsistently following safe work practices, and corrective action for incidents were not being completed in a timely fashion. In addition, information about department specific incidents was not being shared, nor the corrective action taken.

Through the early stages of the pilot project, there were difficulties in implementing the visual display and holding conversations at group huddles in Housekeeping and Laundry Services. It was difficult to meet with the employees for huddles when there were multiple shift start times and large volumes of employees to meet with. An additional barrier was the lack of meeting space to accommodate such a large group.

Outcome from Pilot Project

Since the introduction of the visual display it became apparent that the trending causes of incidents were related to musculoskeletal injuries. Upon further exploration, it became evident that employees were not using proper body mechanics when washing floors, cleaning beds, lifting items, and rushing through tasks. An additional finding determined that it has been quite some time since employees received training in back care and ergonomics. Most employees had only completed training when they were first employed. Others who are long-time employees had not received on-going training.

A plan was developed for Housekeeping and Laundry employees to retrain in body mechanics. A training database is maintained by Occupational Health & Safety for the purpose of tracking when employees received their initial training. It was discovered that there are senior employees that could benefit from recertification in some essential training courses. All employees will be required to have refresher courses and will be required to retrain every two years. Training will cover proper lifting techniques and posturing when completing tasks, such as washing floors and moving fully loaded linen carts.

The Regional Housekeeping Committee has reviewed the current practice of cleaning beds and determined that the existing process was outdated. A new standard operating procedure has been created and will be implemented in the hospital. All employees will receive training on the new procedures. Group sessions will take place where individuals will be exposed to enhanced techniques to clean beds and they will read and sign a document acknowledging that they have received the training. The standard operating procedure will be printed and readily available for employees to review if needed.

All employees receive departmental orientation on or near their first day of work. It was determined that the ergonomics portion is quite generic as it does not go into great detail on proper body mechanics, especially when washing floors. The manager reached out to another hospital that has created a very specific, detailed video on how to mop the floor using proper body mechanics. The video will be used as additional reference when new employees receive onboarding to the department. All existing employees will be required to view the video and demonstrate the ability to use proper body mechanics when mopping the floor.

Results & Evaluation of Pilot Project

From the use of the visual display, the Housekeeping and Laundry Services will be able to decrease incidents related to body mechanics and will create a sense of awareness of the employees' surrounding while cleaning patient rooms and transporting linen carts. Seeing that the visual display is very specific to a location and the cause(s) of injuries employees are able to determine where the potential hazards are and determine why this is happening. Without the use of the visual display the trending causes of injuries would not have been apparent and would not have created the desired impact of awareness. It is a tool management and employees can use to implement change to reduce high risk trends in their areas.

Management has been able to consult with other departments (i.e. Maintenance and Occupational Health & Safety) to repair any carts that may be damaged or other issues that could cause any type of strain when moved.

While the new training program is being developed ongoing conversations with the employees continue to take place. It is important that the employees know they can speak to any concerns they may have regarding potentially unsafe work environments.

7A South Surgery (Patient Care)

Implementation of Pilot Project

As the pilot project was launched in two support services areas, 7AS was one of the patient care areas identified to be part of the project.

Below is a summary of the data that was collected:

- April 1, 2014 to March 31, 2015: a total of 19 reported incidents
- April 1, 2015 to March 31, 2016: a total of 15 reported incidents
- April 1, 2016 to March 31, 2017: a total of 11 reported incidents
- April 1, 2017 to March 31, 2018: a total of 13 reported incidents
- April 1, 2018 to January 16, 2019: a total of 7 reported incidents

After reviewing the data for the 7AS department it became apparent that the main reason for reported incidents was due to patient mobility, such as:

1) Assist patient walk/stand
2) Lifting/lowering patient
3) Transferring patient

Despite the development and implementation of safe work procedures including safe patient handling equipment and training related to patient mobility, incidents resulting from moving patients continued to occur.

Through gap analysis, it was identified that there were concerns in identifying the root cause and providing corrective action for incidents as follow up was not conducted in a timely fashion. There was no consistent sharing of department specific incident information, nor shared what corrective actions had taken place. Employees were inconsistently using the provided patient mobility equipment such as sliders. Although safe work procedures identify the use of sliders, it was noticed that a soaker pad was being used to transfer or reposition patients. Sliders are designed to create ease by sliding against fabric when transferring a patient from a stretcher to bed or vice versa. Soaker pads are not designed to be used when moving a patient even though the size was similar and almost as easy to place under a patient.

It was also identified through gap analysis that patient mobility cards were not consistently being reviewed prior to lifting patients. Reviewing these cards regularly is essential as they identify proper body mechanics and the required number of employees to do a lift. Without a regular reassessment, the potential for injuries increases.

The use of a visual display of injuries and the practice of standard work was to be introduced to the department. Conversations were held at the weekly team huddles to review any incidents that had occurred. It was important that the manager bring to the attention of the employees what was happening in the department. It was expressed that the use of sliders was essential in maintaining a safe work environment and mitigate risk for further injuries.

Outcome from Pilot Project

From the results of the gap analysis, the management team was able to develop strategies to improve overall awareness of the incidents occurring in the area.

Discussions took place to determine why sliders were not being used. At first it was thought that perhaps there was no time for an employee to go and obtain one to move a patient, or perhaps the sliders were difficult to locate. Ongoing conversations with the employees revealed that some employees were not using the sliders as they were not comfortable with transferring the learning received in orientation into practice. This was quickly remedied by involving a member of Occupational Health and Safety team who was able to provide training on proper techniques when using sliders.

When it was discovered that some of the injuries were a direct result of lifting/transferring, not only was proper technique reviewed but also the use of the mobility cards. Mobility cards are displayed near the patients and indicate specific information on the requirements when assisting a patient to move, whether it is a two to three person lift, use of mechanical lift or other patient mobility devices. Any employee performing patient handling can use more assistance than what is displayed if they feel the need, provided that the increased assistance is within the safe work procedures. In some cases, employees were jumping in to assist a patient and not always reviewing the mobility card prior to the assist. Management assured the employees and reiterated the importance of taking the time to review the mobility cards before they went to the aid of a patient. Employees had good intentions in providing excellent care to the patients, but by doing so and not reviewing mobility cards it resulted in unnecessary risk for injuries.

Results & Evaluation of Pilot Project

The implementation of the visual display was certainly impactful for this area. It encouraged daily conversations about injury prevention in addition to identifying opportunities to improve day to day activities.

Utilizing in-house resources, such as the Occupational Health & Safety team, was a contributing factor in the success of correcting and supporting the employees with patient transfers. Once the issue was identified, it was quick thinking and the help of subject matter experts that changed the way in which the transfers were taking place. Our teams worked together to enhance the transfers and ensure proper safe work procedures and techniques were implemented and being followed. Employees are also reviewing mobility cards prior to assisting with patient movement. The patients' mobility is re-assessed and any changes to techniques or use of equipment are documented by a nurse, physiotherapist or occupational therapist. The mobility cards are updated accordingly so employees are made aware when a change in practice has occurred and new methods can be followed to maintain a safe work environment.

For the 7AS department, the visual display was a key element in the success of injury prevention conversations at staff huddles. There are continuous discussions taking place regarding what more can be done to mitigate risk, based on the patterns or trends presenting on the display.

PROPOSED RECOMMENDATION

St. Boniface Hospital is proposing the implementation of a visual display (that identifies cause(s) of injuries, location and injury and body map) to all areas of the hospital.

Although the visual display was primarily focused and tested in the pilot project areas, the visual display has been implemented in other areas as a trial. The Emergency department, Protection Services, and the Mental & Allied Health department have been included in this trial to obtain further feedback from management and employees

With the ability to report incidents in the Incident Tracking System and the use of the visual display the Emergency department was able to identify an increasing risk in the amount of verbal abuse from patients in care. During the daily huddles, employees were able to discuss reasons triggering verbal altercations between patients and/or family members and were then able to develop strategies to alleviate some of the risks. Currently, there are "Respect and Personal Safety" posters that blend into the background and look as though it would be a policy applied only to employees and not for those who enter the hospital seeking treatment. An opportunity exists to review this practice and enhance how we communicate our expectations regarding this policy.

The initial reaction from the manager of the Mental & Allied Health department was that of disbelief. When looking at the visual display there was one particular trend that stood out and that was the vast majority of incidents and injuries were taking place in two patients' rooms out of the entire unit. The team was already evaluating how to provide care and maintain a safe work environment, but the visual display helped solidify the need for a new action plan. A review was conducted and new strategies were implemented regarding how many employees could enter these patient rooms at any given time. Updated practices have been implemented and going forward new graduate nurses or healthcare aides are not to provide primary care without being accompanied by a senior employee for guidance, and all new employees are required to complete a set of training hours prior to providing primary care.

Initial reluctance regarding the use of the visual display was present when introducing it to the Protection Services team. It has since been well received. Engaging the employees in round table discussions related to injury prevention was challenging as it was often viewed as "this is part of the job". By fostering an environment where all are welcomed to share and brainstorm ideas to prevent work place injuries, concerns were raised regarding training and personal protective equipment. These conversations resulted in new training opportunities and a review of personal protective equipment.

St. Boniface Hospital has demonstrated that the use of a visual display to illustrate the types of injuries and where they are taking place has merit. The implementation of a visual display has proven to be an effective tool to enhance and compliment the focus on injury prevention. St. Boniface Hospital highly recommends the use of a visual display and standard work in daily conversations. Other hospitals and sectors could benefit greatly from the lessons learned at St. Boniface Hospital in enhancing an injury prevention program to minimize risks to health care workers.

FINANCIAL SUMMARY

The financial cost to implement a program of this magnitude in a large organization requires the dedication of a full time employee. The project costs exceeded the amount funded by The Workers Compensation Board of Manitoba and St. Boniface Hospital was responsible for any remaining amounts.

All funds were solely for the project and were applied as follows:

Salary and Benefits:	
Project Coordinator	54,982
Knowledge Transfer and Supplies	2,074
Expenditures funded by WCB	**$57,056**

EXECUTIVE SUMMARY

Engaging an organization in the prevention of work-related injuries requires a multi-pronged approach and meaningful involvement from key stakeholders. St. Boniface Hospital launched the use of a visual display of injuries to assist in building an injury prevention program to minimize risks to health care workers. The visual display served as a tool to inform and educate our organization regarding employee injuries. The use of dots to show clusters and patterns reveals trends needing to be addressed. A visual representation of the injuries occurring within each department is useful to provide an overall view of what is occurring and assist in reducing the amount of workplace injuries.

This pilot project was initially tested in two areas within the hospital. These areas were successful in identify trends and implementing strategies to reduce injuries. A third area, not originally part of the pilot project, was flagged as injuries were on the rise. Since implementing the visual display, this area has identified the need for ongoing training opportunities and is currently reviewing and updating standard work procedures.

The visual display has created a sense of awareness regarding workplace injuries and the importance of working together to mitigate and/or eliminate risk. As a result of the implementation of the visual display in each of the pilot project area St. Boniface Hospital has seen an enhancement in our practices and a reduction in workplace injuries.

Implementation of the Injury Prevention Program

The following manual will assist readers in the development of their own visual display of injuries; outlining occupational health and safety system requirements, detailed communication plans and overall project learnings. Should the reader have interest in further details regarding other elements of a successful Health and Safety Program consider contacting Safe Work Manitoba for further guidance.

Occupational Health & Safety Management System

What is a Health and Safety Management System?

A Health and Safety Management System utilizes processes that are designed to decrease the number of incidents and illnesses occurring in a workplace. Success of the system relies heavily on the management commitment to the system, allocation of resources, and employee participation in the system. The scope and complexity of a Health and Safety Management System will vary according to the size and type of workplace. An effective program will meet all of the legislated workplace safety and health requirements in the province of Manitoba. For further information regarding the requirements please see *appendix 1.*

The following elements are the basic components to a Health and Safety Management System. Elements to this system are interdependent upon each other and are the building blocks to a successful Health and Safety Program (Safe Work Manitoba, 2010):

1. Policy
2. Identifying and Controlling Hazards
3. Emergencies
4. Roles & Responsibilities
5. Inspections
6. Chemical & Biological
7. Contractor
8. Training
9. Investigation
10. Participation
11. Evaluation

Incident Reporting, Investigation & Data Management

THE REPORT:

Following an incident, near miss or illness employers must have a system in place for employees to report the occurrence. The report should include details regarding the following:

- Personal information (name, phone number, job title etc.)
- Detailed location of where the incident occurred
- Date and time of the incident
- Time the incident was reported
- Whether the incident tracker was an incident resulting in injury, near miss or an illness
- If this incident resulted in a report only, first aid, medical aid or lost time away from work
- The body parts injured

- Cause(s) of injury
    - i.e.) Bite, indoor/outdoor fall, lifting/lowering, etc.
- A description of the incident
- Interim corrective actions utilized to minimize risks
    - i.e.) should a slip occur as a result of water on the floor, an appropriate interim corrective action would remove the water from the floor to prevent reoccurrence of the incident.

This report should be filled out immediately following an incident so that all pertinent details are recorded. Reports should then be provided to managers or in-charge persons for completion of an investigation into the root cause of the incident so that appropriate long term corrective actions can be put in place to reduce the risk of repeat incidents. Please see *appendix 2* for a sample incident report form.

THE INVESTIGATION:

An investigation is undertaken following an incident to identify any risks which have yet to be identified or risks which have previously been identified, controls that have been put in place, but have not mitigated these risks for employees. Investigations should identify hazards, root causes for the incident and implement corrective actions in order to prevent similar incidents from occurring again.

DATA MANAGEMENT:

An organization must have a means of tracking incidents which occur in their facility. St Boniface Hospital is fortunate in that it has an Incident Tracker System which collects all data related to incidents which are reported. We are able to run reports and select certain data sets, such as injury cause, location, body part affected etc. in order to determine specific information for our visual display of injuries. Without a computerized system, an organization must determine a way to collect data from incident reports and investigations and store it so that the data may be further analyzed in the future, as well as used for populating the display.

Simple weekly/monthly tally tables can be an easy way for organizations to track statistics related to incidents:

Incident Description	Time Loss Claim	Injury Cause	Location	Body Part Affected
Jane Smith slipped and fell on her right knee on the sidewalk outside the hospital main entrance due to ice.	Yes	Slip	Main Entrance	Right Knee
John Doe twisted his back while lifting a heavy box from the floor.	No	Manual Materials Handling	Storage Room D-Block Room # E2017	Lower Back

Based on this information an organization is able to identify if any incident trends are occurring in your facility. It will also assist with populating a display of injuries as it contains all pertinent information for the display.

The Visual Display of Reported Injuries

Property Map

Management teams will receive a map of the designated areas that their employees work in. This is to identify the location of the injury that took place.

Immediately following the incident, the manager (or designate) will be responsible to update the area map with colour coded dots to identify where in that location the injury took place. A red dot will identify the injury of the employee from that area; a blue dot will identify an employee from another area that was injured in this specific location, any of these injuries resulting in time loss will be identified with an "X" in the coloured dot.

Please see *appendix 3* for sample map and appendix 3.1 for a sample property map with dots.

Cause(s) of Incident(s) Chart

By targeting the specific location to which the injury took place and where an employee was injured it will present opportunities to identify any trends and behaviours that can be rectified. With a root cause analysis it can further determine what can be done to prevent the injuries from taking place, i.e.: back care training, is personal protective equipment being used, is it a result of a particular season, etc.

When determining what themes to include with your visual display a number of factors should be considered:

- Top causes of incidents occurring
- Severity of incidents
- Seasonal causes of incidents (i.e. slips, trips & falls, heat exhaustion etc.)
- WCB legislation, employer responsibilities, staff training

With these items in mind you will be able to determine what the pertinent areas are for your review throughout the year. Some examples of potential themes could include:

- Blood/Body Fluid Exposure
- Bruise/Crush/Abrasion
- Burn/Scald
- Chemical/Heat Exposure
- Cut/Laceration/Puncture
- Concussion
- Electrical Shock
- Fracture/Dislocation
- Infection/Infestation
- Psychological
- Repetitive Strain Injury
- Sprain/Strain
- Verbal Abuse

From there, you can break it down further and create criteria that would fall in the categories listed above. Such as:

• Agitation / anger	• Cold / heat / noise
• Animal/Insect bite	• Communicable disease / microorganism
• Assist patient to walk / stand	• Electrical
• Blood/body fluid spill/splash	• Human bite
• Caught in / under / between wall, equipment, door	• Indoors fall

• Chemical	• Lifting / lowering
• Lifting patient	• Repositioning patient
• Mental Health	• Sharp object
• Needle Stick	• Struck / bumped / banged / rubbed / abraded / hit by
• Obstacle on path causing fall	• Substance abuse
• Outdoors fall	• Transferring patient
• Preventing a fall	• Twisting
• Pulling	• Unexpected patient movement
• Pushing	• Wet /Slippery surface causing fall
• Reaching	

Please see *appendix 4* for sample Cause(s) in Incidents(s) chart and appendix 4.1 for sample Cause(s) in Incidents(s) chart with dots.

Body Map Diagram

Management teams will receive a body map that shows the front and back sides of the human body. This is to identify where on the body the employee was injured.

Immediately following the incident, the manager (or designate) will be responsible to update the body map with colour coded dots to identify where on the body the injury took place. A red dot will identify the injury of the employee that works in that area; a blue dot will identify an employee that works in another area that was injured in this specific location, any of these injuries resulting in time loss with be identified with an “X” in the coloured dot.

Please see *appendix 5* for sample body map and appendix 5.1 for a sample body map with dots.

Communication Plan

Managers are to have daily conversations with their teams regarding the prevention of workplace injuries. Discussions around injury prevention will be integrated into the team huddles where employees can participate in conversation by coming up with strategies that they believe are beneficial in creating a safer work environment. Creating awareness, engagement and knowledge transfer around injury prevention will help foster healthy conversations on how to stay safe in the workplace. Development of a Standard Work process can be created to foster ongoing conversations.

Please see *appendix 6* for a sample of the Use of a Visual Display and *appendix 7* for a sample of The Conversations around the Visual Display.

Putting the Visual Display together

The Property Map and the Cause(s) of Incident(s) chart are printed on an 8x10 letter sized paper. The Body Map Diagram is printed on an 11x17 ledger size paper. All 3 forms should be placed onto a larger poster paper. The full visual display should measure roughly 23.5”x21.5” in size.

The visual display should be placed in an area where all employees have access to see, ideally where the daily huddles take place as it can be used as a point of reference.

The dots should be updated shortly after an incident has been reported, and updated by management or their delegate (not the employees who reported an incident).

Please see *appendix 8* for a sample of the Visual Display.

APPENDICES

Appendix 1- Workplace Safety & Health Act

Workplace Safety & Health Program

CONTENT OF PROGRAM

7.4(5) A workplace safety and health program must include:

(a) a statement of the employer's policy with respect to the protection of the safety and health of workers at the workplace;

(b) the identification of existing and potential dangers to workers at the workplace and the measures that will be taken to reduce, eliminate or control those dangers, including procedures to be followed in an emergency;

(c) the identification of internal and external resources, including personnel and equipment, that may be required to respond to an emergency at the workplace;

(d) a statement of the responsibilities of the employer, supervisors and workers at the workplace;

(e) a schedule for the regular inspection of the workplace and of work processes and procedures at the workplace;

(f) a plan for the control of any biological or chemical substance used, produced, stored or disposed of at the workplace;

(g) a statement of the procedures to be followed to protect safety and health in the workplace when another employer or self-employed person is involved in work at the workplace that includes

(i) criteria for evaluating and selecting employers and self-employed persons to be involved in work at the workplace, and

(ii) procedures for regularly monitoring employers and self-employed persons involved in work at the workplace;

(h) a plan for training workers and supervisors in safe work practices and procedures;

(i) a procedure for investigating accidents, dangerous occurrences and refusals to work under section 43;

(j) a procedure for worker participation in workplace safety and health activities, including inspections and the investigation of accidents, dangerous occurrences and refusals to work under section 43;

(k) a procedure for reviewing and revising the workplace safety and health program every three years or more often if circumstances at a workplace change in a way that poses a risk to the safety or health of workers at the workplace; and

(l) any other requirement prescribed by regulation.

(Manitoba, 2015)

Appendix 2

Sample Injury Report

Incident Basics

Employee Name:	
Position:	Registered Nurse (N2)
Home Phone:	
Manager:	
Director:	
Date of Occurrence:	July 5, 2018 23:00
Date Reported:	July 5, 2018 23:37
Reported by:	

Incident Details

Incident Type:	Illness/Injury
Location:	Treatment Room
Equipment/Property Damage:	No
Location specifics:	
Description:	Assisting pt to hold pressure on fistula needle site after hemodialysis- while taking over holding for pt, blood sprayed from AV fistula onto lips, and maybe into mouth.
Interim Corrective Actions:	No action taken
Reporting Delay?	No delay

Illness/Injury Details

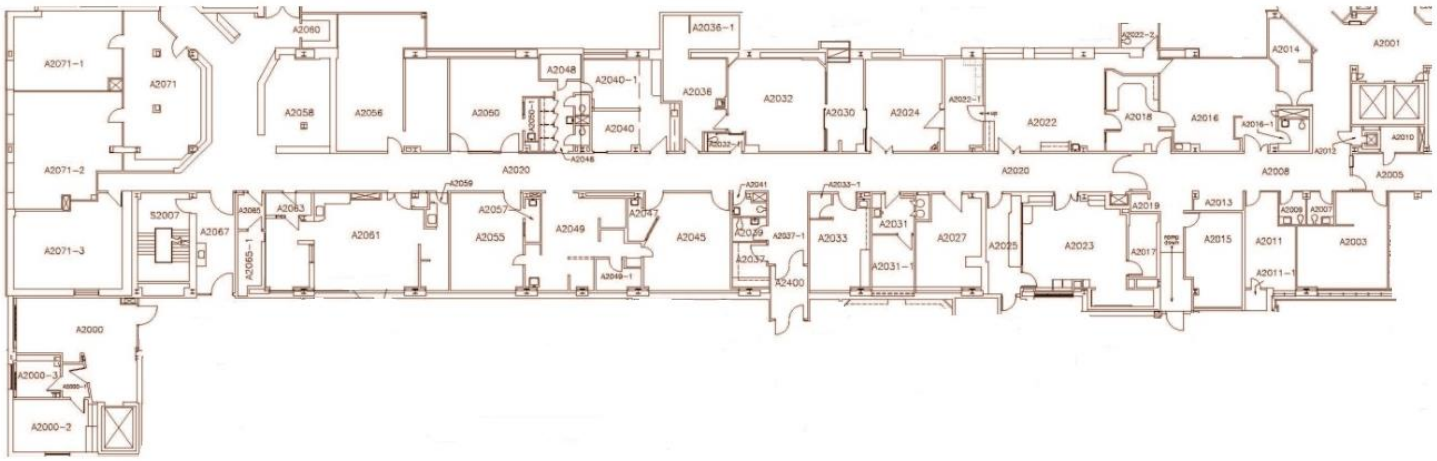
Illness/Injury Type(s):	Blood/body fluid exposure
Region(s) of Body Affected:	None
Illness/Injury Cause(s):	Blood/body fluid spill/splash
Work Missed:	No work missed

Witnesses

Witness Name(s):	No witnesses

Appendix 3

Sample Property Map



Appendix 3.1

Sample Property Map with Dots

Appendix 4

Sample of Causes of Injuries

Incidents from MONTH / YEAR

Number of Incidents	Agitation / anger	Animal/insect bite	Assist patient to walk / stand	Blood/body fluid spill/splash	Caught in / under / between wall, equipment, door	Chemical	Cold / heat / noise	Communicable disease / microorganism	Dementia	Dust / allergens	Electrical	Human bite	Indoor fall	Lifting / lowering	Lifting patient	Mental health	Needle stick	Obstacle on path causing fall	Outdoors fall	Preventing a fall	Pulling	Pushing	Reaching	Repetitive strain	Repositioning patient	Sharp object	Struck / bumped / banged / rubbed / abraded / hit by	Substance abuse	Transferring patient	Twisting	Verbal abuse	Wet / slippery surface causing fall
23																																
22																																
21																																
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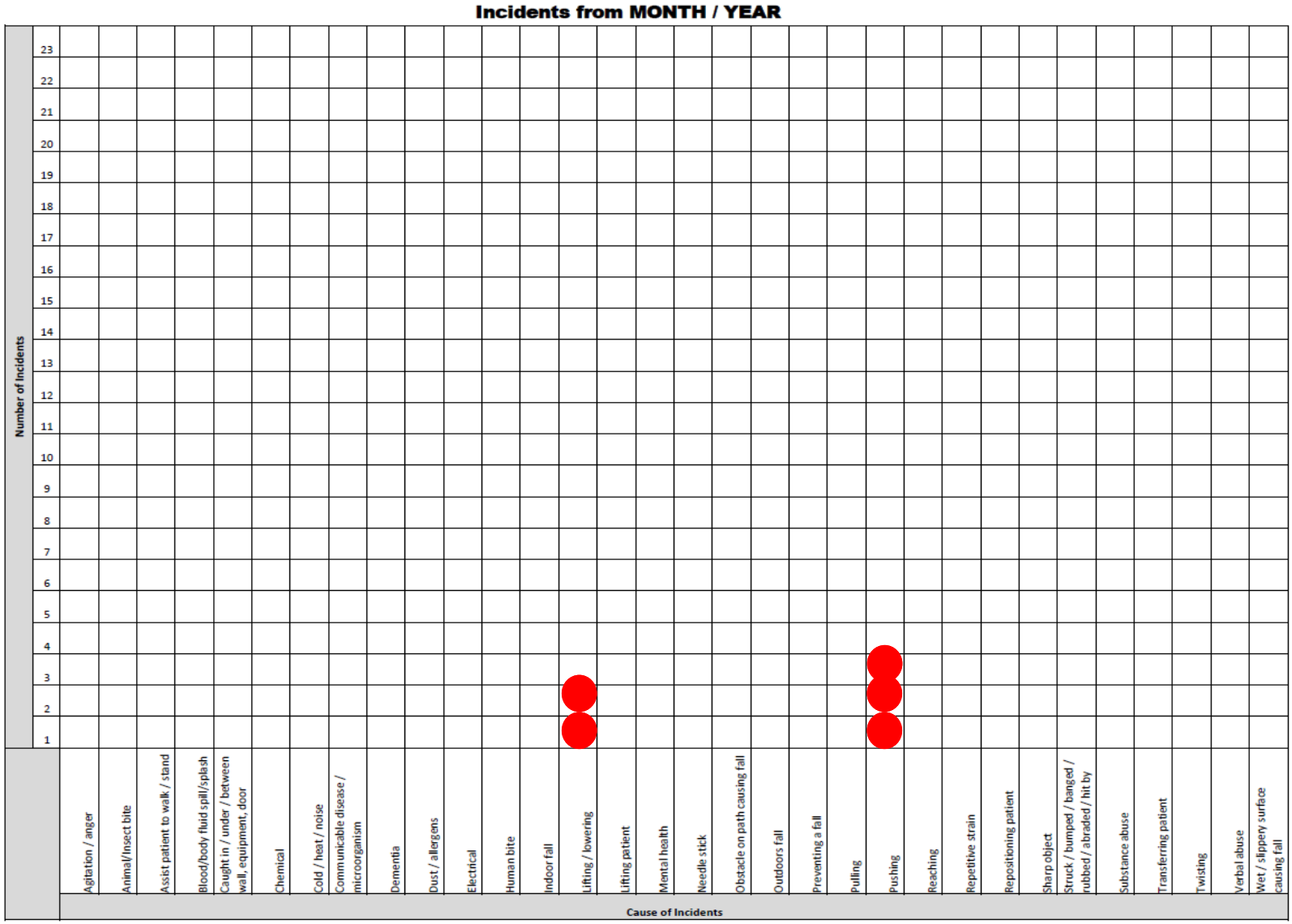
Cause of Incidents

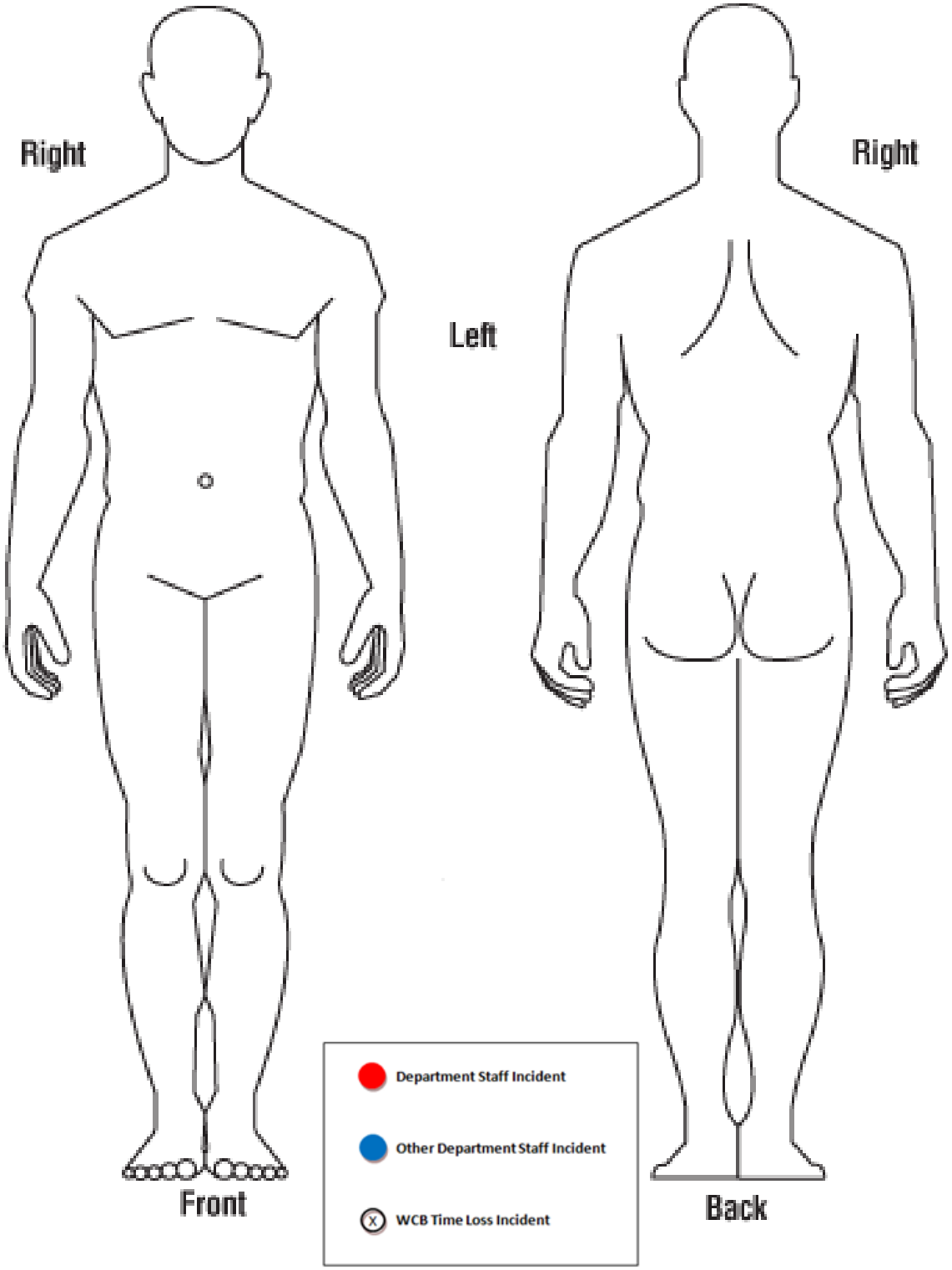
Appendix 4.1

Sample of Causes of Injuries with dots



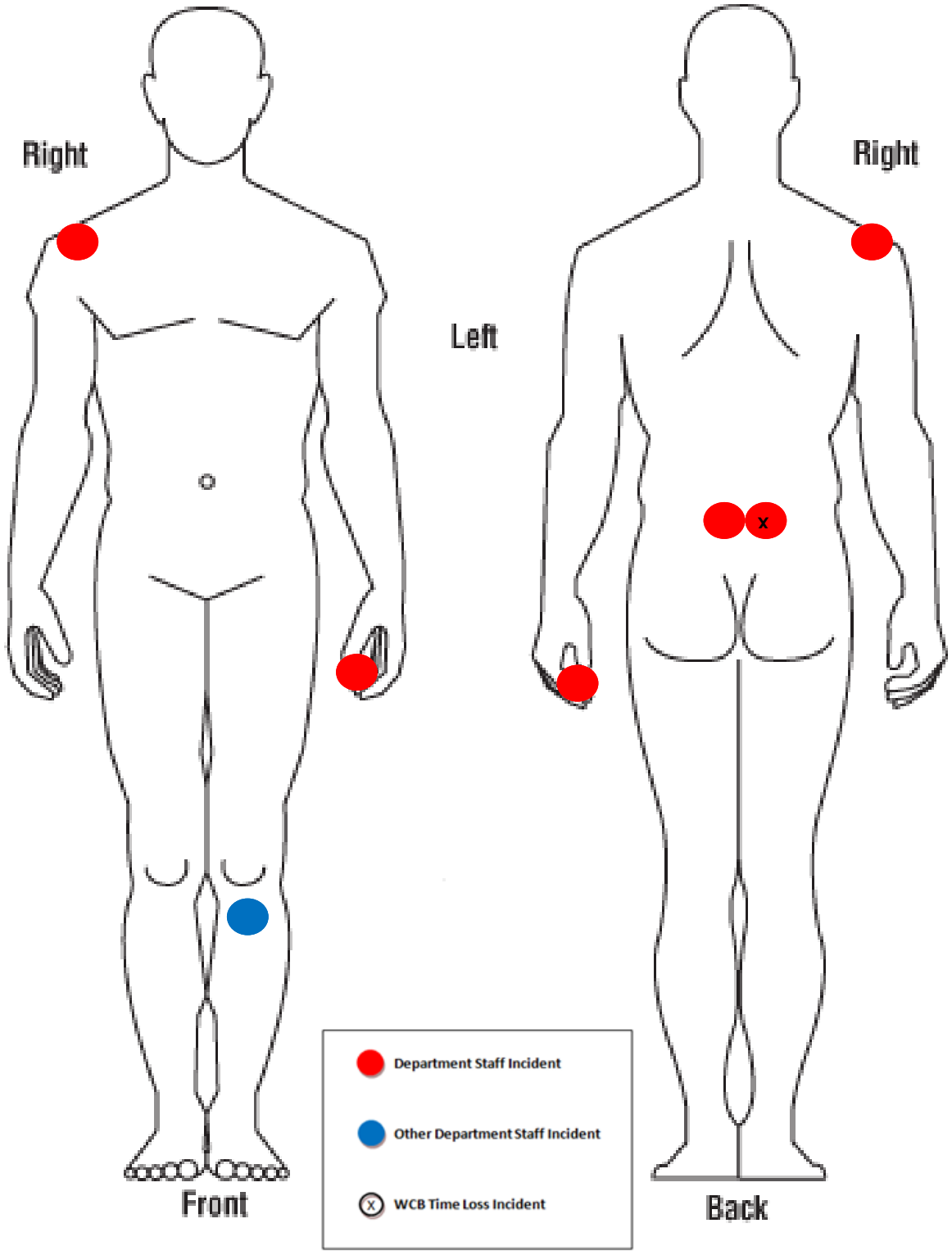
Appendix 5

Sample Body Map Diagram



Appendix 5.1

Sample Body Map Diagram with Dots



Appendix 6

Sample of Use of a Visual Display

Hôpital St-Boniface Hospital

Standard Work

System:	Employee Injury Prevention	Process:	Use of a Visual Display

Purpose: *To have a daily conversation with employees and have a clear and shared understanding of the current health and safety risks, key updates and acknowledgments that have occurred in the last week or are expected to occur in the next week as well as any shared learning from risks that have been resolved.*

Results:

- Have a daily visual tracker of what types of injuries are occurring in the area/unit

Definitions:

Risk –Something that increases the possibility of an incident occurring. Something that has either happened already or has a potential for occurring.

Consultation – Requires a deliberate discussion with an expert of peer professional in order to seek advice.

Roles & Expectations:

- *Facilitator* – Starts the huddle by setting out objectives and rules; ensures that the huddle keeps moving and is focused, and summarizes what actions need to be taken after the huddle
- *Recorder* – Records on flip chart all identified risks, updates and actions.
- *Observer/Coach* – Observes the overall functionality of the huddle, including: take time, risk identification, problem-solving during the huddle and blaming. Coaches individuals after the huddle.

An up to date visual display of injuries will be maintained for each unit and department at SBH. The visual display will outline areas of the hospital where incidents are occurring, the most injured body part for each incident as well as unit/department specific information regarding injury trends, opportunities for improvement and tips for staff safety.

Ground Rules or Key Assumptions:

- Start on time
- One speaker at a time
- No problem-solving during the huddle
- No blaming
- Be prepared
- Full attention given (i.e. no checking phones)

Supporting Tools:

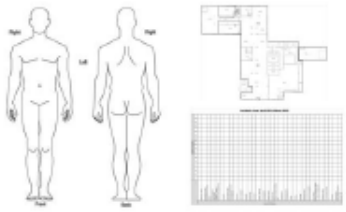
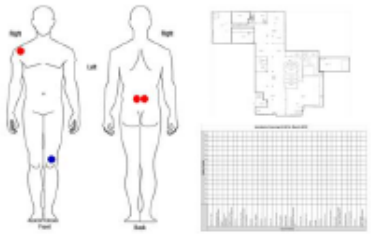
- Body Map
- Area/Unit map
- Cause(s) Graph
- Incident tracker

Page 1 of 4 Revision Date: July 3, 2018

Hôpital St-Boniface Hospital

Standard Work

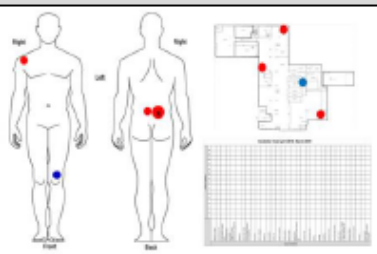
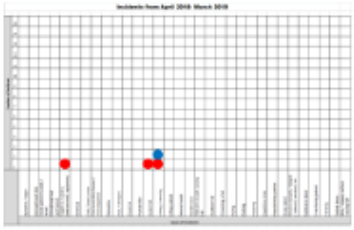
System:	Employee Injury Prevention	Process:	Use of a Visual Display

Step #	Description	Key Points / Images	Reasons Why	Who	Time
	An injury prevention display will be posted in a highly visible location in your unit/department. The display will consist of the following: - An A3 sized body map diagram - A letter sized map of your department/unit - A letter sized cause of illness/injury chart			Manager or their designate	Each fiscal year
	Once the display has been set up, following the notification of a work related incident, managers will update the visual display of injuries. Colour coded dots will be utilized: - Red dots will be utilized to identify injured staff from your unit/department - Blue dots will be utilized to identify injured staff from other departments/units who are injured in your area		Departments/units will order and keep stock of the following items from Grand and Toy in order to populate their display: - Red dots item id #: 14001-0 - Blue dots item id # 14003-0	Manager or their designate	As needed

Hôpital St-Boniface Hospital

Standard Work

System:	Employee Injury Prevention	Process:	Use of a Visual Display

Step #	Description	Key Points / Images	Reasons Why	Who	Time
	Display will be populated with the colour coded dot to highlight the following: - Location of the incident - Most affected body part - The cause of injury/illness - If time loss occurred as a result of the incident It will be identified by an **X** through all dots associated with the incident			Manager or their designate	After an incident
	Run Chart will be populated to highlight the following: - Number of occurrences - Tracking of different causes of injuries			Manager or their designate	After an incident
	On a daily basis all unit/department managers will review with staff, their visual display of injuries to determine if there are any trends occurring in their area/unit.	*If no injuries occurred over the last 24 hours/weekend, **celebrate** that no one was injured.* If an injury had occurred, review the following: - Location of the incident - Most affected body part - The cause of injury - If time loss occurred as a result of the incident Ask staff what could be done to prevent/mitigate the injury What standards are out there	Safety conversations may be integrated with shift to shift huddles or the areas management system improvement huddles	Manager or their designate	Daily

Hôpital St-Boniface Hospital

Standard Work

System:	Employee Injury Prevention	Process:	Use of a Visual Display

Step #	Description	Key Points / Images	Reasons Why	Who	Time
	Data collected based on incidents occurring in the area of concern will be reviewed and compared to determine if any trends exist.			Manager and HR	As needed
	The display will be populated in this way for each fiscal year. April 1 of each year a new copy of each of the display elements will be posted: - Location map - Body map diagram - Injury/illness cause chart			Manager or their designate	Annually on April 1st
	All display items can be kept for reference and comparison from previous years.			Manager and HR	Annually on April 1st

Appendix 7

Sample of Conversations around the Visual Display

Hôpital St-Boniface Hospital

Standard Work

System:	Employee Injury Prevention	Process:	Conversations around the Visual Display

Purpose: *To have a daily conversation with employees and have a clear and shared understanding of the current health and safety risks, key updates and acknowledgments that have occurred in the last week or are expected to occur in the next week as well as any shared learning from risks that have been resolved.*

Results:

- Have a daily visual tracker of what types of injuries are occurring in the area/unit

Definitions:

Risk –Something that increases the possibility of an incident occurring. Something that has either happened already or has a potential for occurring.

Consultation – Requires a deliberate discussion with an expert of peer professional in order to seek advice.

Roles & Expectations:

- *Facilitator* – Starts the huddle by setting out objectives and rules; ensures that the huddle keeps moving and is focused, and summarizes what actions need to be taken after the huddle
- *Recorder* – Records on flip chart all identified risks, updates and actions.
- *Observer/Coach* – Observes the overall functionality of the huddle, including: take time, risk identification, problem-solving during the huddle and blaming. Coaches individuals after the huddle.

An up to date visual display of injuries will be maintained for each unit and department at SBH. The visual display will outline areas of the hospital where incidents are occurring, the most injured body part for each incident as well as unit/department specific information regarding injury trends, opportunities for improvement and tips for staff safety.

Ground Rules or Key Assumptions:

- Start on time
- One speaker at a time
- No problem-solving during the huddle
- No blaming
- Be prepared
- Full attention given (i.e. no checking phones)

Supporting Tools:

- Body Map
- Area/Unit map
- Cause(s) Graph
- Incident tracker

Step #	Description	Key Points / Images	Who	When
1.	Gather together	Every shift change, meet in the NAME OF LOCATION.	Manager Supervisor All staff	Every Shift Change

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Hôpital St-Boniface Hospital

Standard Work

System:	Employee Injury Prevention	Process:	Conversations around the Visual Display

2.	**Introduction/ Ground Rules**	Facilitator opens huddle by briefly explaining the objective of the huddle.	Facilitator	
3.	**Follow up**	Review any follow up on identified risks and corrective actions identified during the last huddle.	Facilitator, any staff	20s Takt time
4.	**Review identified risks occurring since the last huddle**	Review any new incidents, hazards and risks which have occurred in food services since the last huddle: If uncomfortable reviewing info regarding a specific incident, remind staff about the hazard which caused the incident. i.e.) slip, trip, fall incident remind staff to clean up spills as soon as they are identified.	Facilitator	After follow up
5.	**Round Table**	Q1: Ask staff: Do you have any concerns related to potential risk today? Q2: Ask Staff: Do you have the PPE you need to prevent burns? (leave this question out until we have new products) Q3: Ask staff: Have you identified any new safety risks?	Facilitator & All staff in attendance	After Corrective action review
6.	**Recognitions**	Ask: Are there any recognition for working safely?	Facilitator & all staff in attendance	After round table
7.	**Huddle Closes**	Facilitator announces that the huddle has concluded.	Facilitator	After recognitions

Hôpital St-Boniface Hospital

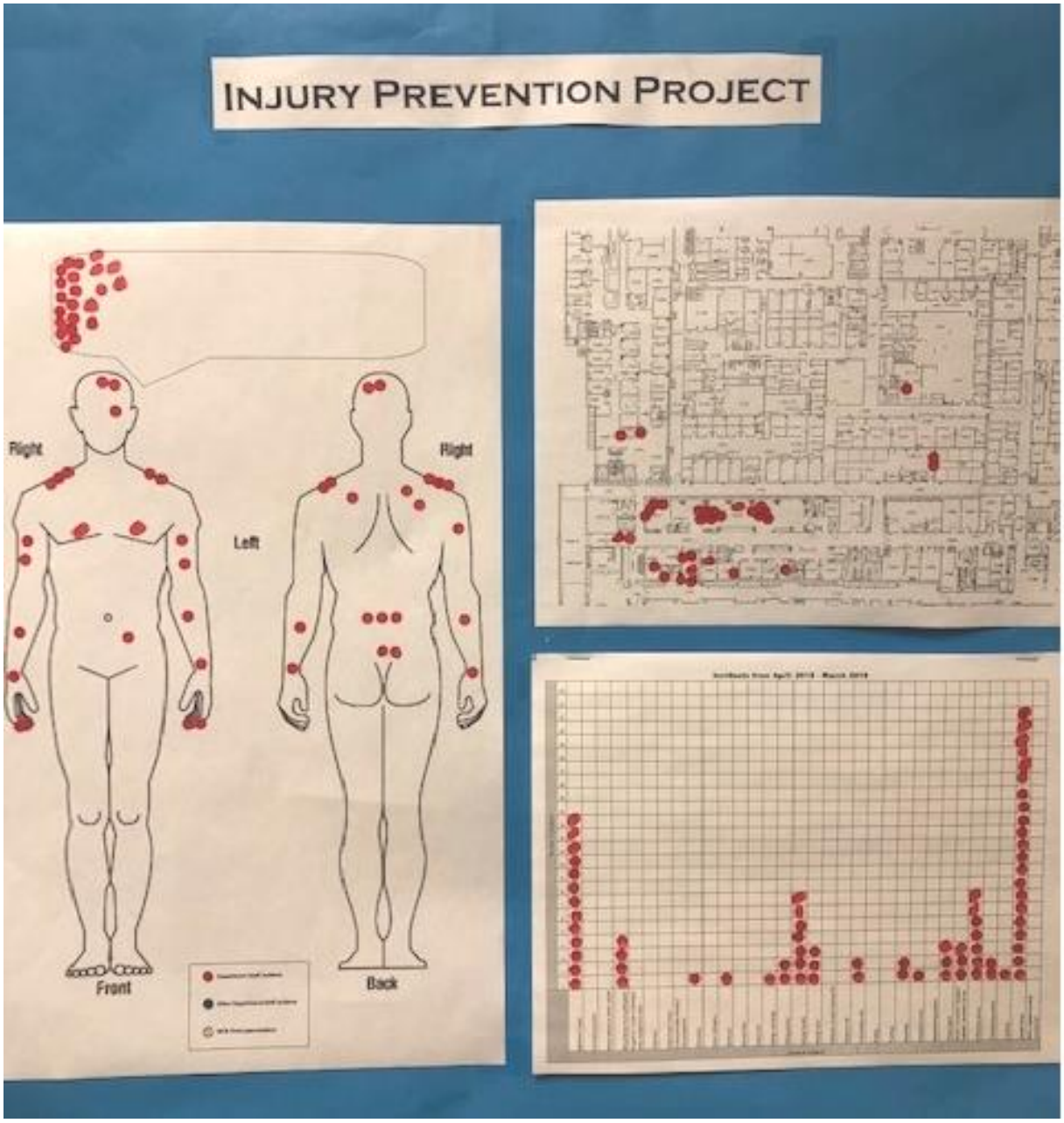
Standard Work

System:	Employee Injury Prevention	Process:	Conversations around the Visual Display

8.	**Document risks/ updates and actions**	Post huddle, the Recorder will update: The Action log and send to the Manager of Food Services and all Supervisors.	Recorder	Within one hour of huddle
9.	**Process Insights**	Gather insight of what is going well, not going well and what can be improved and any key learning.	All employees	Weekly

Appendix 8

The Visual Display



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Work Safe Manitoba. (2010, June). *Developing a Workplace Safety & Health Program Guide.* Retrieved February 7, 2017, from Safe Work Manitoba: http://safemanitoba.com/guide-programs