Health

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Health

Main points

In Chapter 5 of our 2002 Fall Report – Volume 2, we reported the results of our audits of the Department of Health and the related Crown agencies for the year ended March 31, 2002 except for our audit of the Uranium City Hospital (Hospital). We have completed the audit of the Hospital. The Hospital's Board of Governors is responsible to oversee its performance. The Board needs to improve how it directs and monitors the Hospital. For example, the Board needs to approve the Hospital's financial and operational plans and receive better decision-making information from management.

We audited Regina Qu'Appelle and Saskatoon Health Regions to assess whether they used best practices during 2002 to reduce the prevalence of back and shoulder injuries to care staff.

On average, over 10% of workers suffer injuries of all types annually in these two regions. Managers in both regions express concern about injuries to care staff and actively seek solutions. However, during 2002, neither region adequately used best practices to reduce work-related back and shoulder injuries to care staff. We make three recommendations. Boards need to place priority on safety in the workplace. Senior managers need to evaluate the impact on injury rates of current staffing patterns and the use of mechanical aids for positioning patients. Occupational health committees should monitor injury trends and alert senior managers to hazards that have not been fixed.

Effective action requires all participants to take steps to reduce injuries. We encourage staff, managers, and boards of all health regions to do more to reduce injuries in the workplace.

Introduction

The Department of Health's mandate is to protect and improve the health of Saskatchewan people. To do this, the Department provides policy direction, direct services, and funding to health providers and agencies.

In Chapter 5 of our 2002 Fall Report – Volume 2, we reported the results of our audits of the Department of Health and related Crown agencies for the year ended March 31, 2002 except for our audit of the Board of Governors, Uranium City Hospital. This chapter reports the results of our audit of the Hospital.

As well, we report our assessment on whether the Saskatoon and Regina Qu'Appelle regional health authorities used best practices to reduce the prevalence of work-related back and shoulder injuries to care staff.

Reducing injuries to health workers

In Saskatchewan, health care workers in hospitals and long-term care centres are among the five occupations most likely to be injured at work. In 2001, health care workers had more injuries than construction industry workers.[1]

Between 10% and 20% of health workers are injured annually in many long-term care centres, hospitals, and home care services. In a few Saskatchewan health care facilities, up to 32% of health care workers are injured annually.[2] Some facilities achieve injury rates below 5%. Although not all injuries result in time away from work (i.e., time-loss injury), for those that do, each injury on average lasts 32.7 days.[1] Back and shoulder injuries combined account for one third of the time lost from work.[3] Repeat injuries are common.

Many of these injuries stem from lifting and moving patients. Health care workers who most commonly reposition patients are care staff (i.e., attendants, aides, licensed practical nurses, and registered nurses). Injuries are caused by factors related to the environment, equipment, staff, and patients. Most injuries are caused by more than one factor.

[1] Saskatchewan Workers' Compensation Board, *2001 Annual Report*.
[2] Saskatchewan Association of Health Organizations Provincial Incident Reports 2002.
[3] Saskatchewan Workers' Compensation Board, *2001 Statistical Summary*.

About 1,400 incidents resulting in injuries that require medical attention occur in Saskatchewan's two largest health regions every year.[4] Injured workers suffer pain and risk disability. Some injured workers are no longer able to work in health care. Injuries may lead individuals to change careers or retire early.

From a human resources perspective, injuries in health care workplaces mean fewer care staff to provide care. Canada and many other countries already face a shortage of some types of care staff. The further loss of qualified care staff due to workplace injuries is a serious problem. Every year, Canada loses the equivalent of almost 9,000 full-time nursing positions due to injury and illness.[5]

From a legal perspective, all employers in Saskatchewan have a duty to "ensure, insofar as is reasonably practicable, the health, safety and welfare at work of all of the employer's workers" (section 3a *The Occupational Health and Safety Act*, *1993*). In practice, employers and managers are responsible to keep the workplace safe. Each worker also is responsible to take actions that protect their own health and contribute to the safety of their co-workers.

The Department of Labour and the Saskatchewan Association of Health Organizations (SAHO) help health care employers to ensure a safe work environment. The Department of Labour is responsible to develop, promote, and enforce standards relating to working conditions that are safe for workers. The Workers' Compensation Board (WCB) designates nine agencies as safety associations for large industries in the province. SAHO is the safety association for the health regions. In that role, SAHO develops programs (e.g., Transfer-Lift-Reposition Program), offers training, collects data, and reports the rate of injuries in each health care facility.

From a financial perspective, neither the Department of Health nor the regions could tell us the total cost of injuries to the health system. However, given the number of injuries, costs are likely high. In Saskatchewan, the Government pays these costs through the health regions and the WCB. In 2001, WCB payments for treatment,

[4] Based on the Workers' Compensation Board's 2001 summary of incidents and injuries provided to the individual health regions.
[5] Canadian Nursing Advisory Committee. *Final Report 2002* ('The burden of the shortage').

rehabilitation, and lost wages were about $6 million per year for the two largest regions. Expenses for sick time, replacement workers, and overtime could be significant.

Health regions pay premiums to the WCB to compensate workers who suffer workplace injuries. Health regions with high injury rates also must pay additional premiums and surcharges to the WCB. In total, the two largest health regions paid the WCB $10.9 million in 2001 and $8.9 million in 2002. The amount fluctuates each year with no clear trends.

During times of staff shortages, the human and financial costs may be higher. Health regions sometimes pay overtime to staff for working extra hours, for example, to replace their injured co-workers. This practice may create a cycle of injuries. Canadian researchers explain that as overtime increases, sick time and the rate of time-loss injuries increases.[6,7] As more staff work overtime, injury rates may increase, staff shortages may become more severe, even more overtime is required, and costs spiral higher.

Background

Health regions must set priorities to manage within the resources allocated to them by the Department of Health. In 1997, the Department began to allocate $1.8 million annually specifically to address workplace safety issues in the health sector in addition to capital funding. For example, the Department gives each of the two largest health regions about $350,000 annually. The Department told us it now includes this money in the health regions' base budgets. Managers use this money for safety facilitators, equipment, training, return to work programs, and improvements related to workplace health.

Health regions must also set priorities in the context of other events in their environment. In 2002, the Government passed *The Regional Health Services Act* to reorganize the boundaries of 32 districts and create 12 health regions. As a result, the Government appointed new members to health region boards. The new regions also re-shaped their management

[6] O'Brien-Pallas, Thomson, et al. (2001 Spring). The economic impact of nurse staffing decisions.
[7] Shamian, O'Brien-Pallas, et al. (2001 October). Effects of job strain, hospital organizational factors individual characteristics on work-related disability among nurses.

teams. In addition, during 2002, health regions coped with an extended job action by various support and therapy staff.

In health regions, managers play critical roles to ensure the safety of their staff and patients. Senior managers authorize policies and strategies to manage risks (e.g., vice-presidents, chief executive officers). General managers authorize spending and monitor standards of care. Unit managers supervise staff, liaise with other care providers, coordinate changes in the environment, and represent their service area on various committees.

This chapter outlines our audit of the use of best practices to reduce work-related back and shoulder injuries in Regina Qu'Appelle Health Region and Saskatoon Health Region. The chapter describes the best practices we expect the health regions to use, our main audit findings, conclusions, and recommendations.

Best practices to reduce injuries

The risk of injury to health care staff is well known. Extensive research from several countries for over 20 years describes practices that work and those that do not. We expect health regions to use best practices to limit the prevalence of back and shoulder injuries to care staff.

The health care environment is busy, noisy, and distracting. Patients are often agitated and may move unexpectedly. In this environment, some injuries are likely to occur. Best practices are essential to reduce the number and severity of those injuries.

The recommendations of the Canadian Centre for Occupational Health and Safety, reports of other auditors, and key variables identified in the research literature influenced the best practices below. These best practices form the basis of our audit (see exhibit).

We confirmed these best practices as reasonable standards for use in well-managed health care agencies with:

- the Canadian Centre for Occupational Health and Safety;

- the Canadian Nurses Association including the Canadian Occupational Health Nurses Association;
- the Department of Labour, Occupational Health and Safety Division; and
- the Saskatchewan Association of Health Organizations, Workplace Health and Safety Services.

The Department of Health, Regina Qu'Appelle Health Region, and Saskatoon Health Region accepted these as best practices.

Exhibit—Best practices to reduce back and shoulder injuries

To demonstrate adequate use of best practices to reduce the prevalence of work-related back and shoulder injuries to care staff, health regions should:

- Provide a work environment that fosters safety and health
  - provide a written program of procedures for moving patients,
  - provide mechanical aids to reduce the risk of injury,
  - provide staffing patterns that support injury reduction, and
  - redesign hazardous tasks and work-areas.
- Educate care staff to reduce risk of injury
  - inform staff of risks and signs and symptoms of injury,
  - teach staff to eliminate hazards or avoid unnecessary risk, and
  - promote actions that minimize risk of back and shoulder injury.
- Show commitment to reduce the prevalence of injuries
  - emphasize safety and injury prevention in the workplace,
  - support injured care staff for a safe/early return to work,
  - monitor compliance with established policies, and
  - monitor agency-wide trends of hazards/incidents/injuries.

Conclusion and recommendations

We concluded that during 2002, the Regina Qu'Appelle Health Region and the Saskatoon Health Region did not adequately use best practices to reduce the prevalence of work-related back and shoulder injuries to care staff.

1. We recommend that the boards of the Regina Qu'Appelle and Saskatoon Health Regions commit to workplace safety as a priority, and that the boards:

- **set specific targets to reduce work-related injuries to care staff in the short term;**
- **allocate resources to achieve the targets (e.g., staff or mechanical aids);**
- **receive frequent reports about injury rates and actions to reduce injuries; and**
- **hold senior managers accountable to reduce injuries.**

2. **We recommend that the Regina Qu'Appelle and Saskatoon Health Regions analyze the unit staffing patterns that are associated with high and low injury rates, and implement the lessons learned.**

3. **We recommend that the occupational health committees of the Regina Qu'Appelle and Saskatoon Health Regions:**

- **monitor injury trends at least quarterly;**
- **analyze the causes of injuries in areas with high injury rates at every meeting; and**
- **make written recommendations to senior management and their board to fix unresolved causes of injuries.**

Our audit

The objective of this audit was to assess whether two large health regions adequately used best practices to reduce the prevalence of work-related back and shoulder injuries to care staff. We defined care staff as aides, attendants, licensed practical nurses, and registered nurses. We examined the use of best practices in the Regina Qu'Appelle Health Region and the Saskatoon Health Region during January 1, 2002 to December 31, 2002.

We did not examine practices used in home care services or affiliate agencies not owned by the regions. We did not expect that these new health regions would have integrated policies for all care settings during

2002. We expected that policies would differ among agencies within a region and looked for predominant practices.

We focused on the systems and practices of the former Regina and Saskatoon health districts that were in use in hospitals and long-term care centres owned by these two health regions. Our audit examined practices at the General and Pasqua hospitals, and Wascana Rehabilitation Centre in Regina; and at the City and Royal University hospitals, and Parkridge Centre in Saskatoon.

We examined policies, reports, training programs, and work design including access to mechanical lifts and equipment for positioning patients. In addition, we interviewed key officials including occupational health directors and 16 unit managers. When we found policies or job descriptions relating to workplace safety, we looked for evidence that the region took the actions described.

We considered proposals and plans. However, we did not give these as much weight as practices in use during 2002. We saw several proposals in both health regions that were put forward during 2002, but not implemented by April 2003.

To carry out this audit, we followed the Standards for Assurance Engagements established by The Canadian Institute of Chartered Accountants.

Detailed findings

For each best practice to reduce the prevalence of back and shoulder injuries to care staff (injuries), we set out what we expected in italics, and our audit findings. What we expected includes some highlights of what is required by *The Occupational Health and Safety Act, 1993* and its regulations.

Provide work environments that foster safety and health

We expected health regions to communicate to staff written procedures for lifting and moving patients. We also expected regions to reduce the risk of injury with appropriate mechanical aids, guidelines for staffing patterns, and reasonably prompt design of hazardous tasks and work

areas. The Occupational Health and Safety Regulations and the Labour Standards Act require staffing patterns that allow for rest and recovery, appropriate equipment in good repair, and control of workplace hazards.

Written program communicated

Both health regions had a written program related to lifting and moving patients. The Regina Qu'Appelle Health Region communicates its Back Management Program to staff prior to their first shift of work. In Saskatoon, new staff members learn about the Transfer-Lift-Reposition Program during their first month at work.

The Saskatoon Health Region adopted the Transfer-Lift-Reposition Program in April 2002.[8] The Region plans to phase in the Program as resources allow. By July 2003, the Region expects to introduce the Program to all staff at City Hospital and Parkridge Centre. The Region plans to introduce the Program to Royal University Hospital in late 2003 after it has evaluated the Program's impact.

Lifts and other mechanical aids

In any industry that requires workers to move heavy objects, employers provide equipment to lift objects efficiently and safely. Appropriate equipment makes it possible for workers of any size, shape, or age to move objects without harming the worker or risking damage to the object.

In the health system, the objects most commonly lifted are patients. From the perspective of moving an object, patients are large, heavy, and awkward. In addition, they may jerk or move in unexpected ways. Many factors limit the ways that care staff can lift a patient manually (e.g., the patient's condition, treatment machines near the bed). Without appropriate lifting equipment, care staff may have to bend, twist, pull, and lift all at once. Lack of equipment increases the risk of injury to care staff. It also reduces the safety of patients who are at risk of falling or being dragged across bedding.

Both regions had policies to make maximum use of equipment to help staff. Neither region had a policy to assess equipment needs regularly.

[8] Saskatchewan Association of Health Organizations established the Transfer-Lift-Reposition Program in 1997. The Program is used in many health regions to control workplace hazards and reduce injuries.

The Saskatoon Health Region assessed its equipment needs in 1998 and 2001. The Region's staff has good access to a wide range of mechanical aids to help lift or move patients. Although the supply is limited, each facility had some equipment for patients weighing in excess of 300 pounds. Managers told us that such patients are increasingly common.

The Regina Qu'Appelle Health Region asked its managers to assess required equipment in December 2002. At that time, almost one third of unit managers asked for additional basic equipment to lift or reposition patients. The Region told us that it plans to purchase more mechanical aids and electric beds gradually over several years, beginning in early 2003. The Region rents special equipment when needed for heavier patients.

Regularly checking equipment reduces the risk that it will break while in use. During 2002, neither region had a policy to ensure preventive maintenance of their lifting equipment in acute care settings. Saskatoon Health Region is developing a computerized preventive maintenance system. Long-term care centres in both regions have a program to do quarterly preventive maintenance on lift equipment. Managers told us that both regions repaired broken equipment within 24 hours unless the required parts were not readily available.

Employers are responsible to provide sufficient quality and quantity of mechanical devices in good working order to protect the health and safety of workers.[9] Basic devices such as pivot discs, lifts, slings, and slider sheets provide a mechanical advantage that makes moving easier and safer for the patient and staff. Lifts designed to move heavier patients are also essential for the safety of patients and staff.

Some larger equipment is also highly recommended as basic equipment by industry experts.[10] Electric beds allow care staff to position a patient without straining in awkward positions. Electric beds also allow recovering patients to adjust their own position without help from care staff. In addition, some provinces use overhead lifts extensively.[11] Overhead lifts improve the safety of patients and staff. This is particularly true in

[9] *The Occupational Health and Safety Regulations*—81-3(b) and 470-1(d).
[10] Department of Labour ergonomics expert, British Columbia WCB preventive services expert, attached references and also www.ohsah.bc.ca.
[11] After research and consensus building in 2002, the Workers' Compensation Board of British Columbia gave $6 million to health regions to enhance mechanical aids with particular attention to overhead lifts.

situations where patient care requires many care staff and treatment machines to be near the patient at the same time (e.g., operating room, emergency, intensive care).

Staffing patterns

A staffing pattern refers to the way that managers arrange for staff to provide care for patients around the clock. It includes the number of staff and the staff mix (e.g., attendants, licensed practical nurses, registered nurses). It also includes the duration of regularly scheduled shifts (e.g., 4, 8, or 12 hour shifts), the total hours worked due to overtime, and the total consecutive number of shifts.

Staffing is a two-edged sword for any service-based industry. Various combinations of staff qualifications and hours may improve quality and safety, but may also increase the cost. In the health system, staffing is complex due to a short supply of some types of care staff and the need for specific skills on particular units.

Collective agreements influence staffing patterns. Both Canadian Union of Public Employees (CUPE) and Saskatchewan Union of Nurses (SUN) collective agreements have a workload clause to protect staff from unsafe or excessive workloads. Both collective agreements also have clauses limiting the number of consecutive shifts that the employer may schedule for each employee. In addition, the CUPE agreement requires that CUPE care-staff members with seniority must be the first to be given the opportunity to work overtime regardless of the number of consecutive shifts they have already worked.

Managers in Regina Qu'Appelle Health Region and Saskatoon Health Region told us that they use a master rotation to guide staffing patterns. The master rotation authorizes a set number of staff with various qualifications for each shift. Neither region had a policy to adjust the master rotation periodically in response to the frequency of injuries.

The managers told us they focus on finding the number of staff required for patient care. Staff safety is not specifically considered. Most unit managers told us that they had a limited pool of casual and part-time workers upon whom they could call when regular staff are not available

due to training, vacation, illness, etc. A few units had virtually no backup staff with the required qualifications.

Neither region has a policy for the maximum number of hours nor number of consecutive shifts care staff actually work. Some unit managers told us that care staff often work overtime hours so as not to leave their units short-staffed. Half of the unit managers we interviewed used more overtime hours than they preferred.

Overtime is a staffing practice that leads to fatigue. Fatigue significantly increases the risk of error and injury. Over-tired care staff put their co-workers and patients at serious risk, as well as themselves. Saskatoon City Hospital uses alternative solutions to overtime (e.g., a central pool of relief staff, full-time relief positions shared among units).

Managing staffing in the health system is complex. Sometimes staff shortages mean that the only available alternative to overtime is to close beds by not admitting patients to vacant beds. Both regions told us that they routinely close beds for vacation periods or other known staff shortages. They also close beds occasionally if not enough staff is available for safe patient care. The role of these large regions as referral centres for the most seriously ill patients sometimes limits their ability to close beds.

Redesign of hazardous situations

In both regions, care staff routinely assessed patients' ability to move, but did not consistently record for others the best way to move that patient. Care staff verbally shared best techniques to move patients. Verbal messages about risk are effective only if an informed staff member is always at hand.

Saskatoon Health Region had processes to identify and redesign hazardous tasks. The Region began using a job-safety analysis process in 2001 and redesigned tasks by adding mechanical aids and a teaching program. The Regina Qu'Appelle Health Region told us they use a similar process to redesign tasks and will begin to use job-safety analysis and specific plans for safety in 2003.

Both regions used occupational health committees in each facility to inspect each work area for safety hazards and recommend changes. On these committees, employer and employee members identify a broad range of safety hazards. The committees' workplace inspection reports showed that during 2002 they did not focus their attention on the major causes of injuries. The committees did not give senior managers or the board a list of outstanding hazards on which managers had not yet taken action.

In both regions, the unit managers and their staff initiated the redesign of tasks or work areas identified as hazardous. Unit managers report to general managers who have authority to allocate funds to redesign tasks. Major redesign of work areas requires further approval from senior managers, the board, and sometimes the Department of Health, for example for capital construction. We did not find evidence that managers or occupational health committees regularly monitored action on major concerns.

Both regions had coordinating committees made up of the co-chairs of the occupational health committees in each of their facilities. During 2002, the coordinating committees in each region responded to individual incidents. The regions did not analyze trends and design corrective action to reduce recurring hazards that cause injuries.

Educate care staff to reduce risks

We anticipated that care staff would be educated to reduce the risk of injury. We expected the regions to inform staff of risks, signs, and symptoms of injury and to teach staff ways to eliminate hazards or avoid unnecessary risk. We expected that managers would encourage staff to minimize the risk of injury. The Occupational Health and Safety Regulations require employers to inform staff about risks of injury and to educate them about signs and symptoms that staff should report.

Inform staff of risks and symptoms

Back and shoulder injuries may occur without causing pain. Symptoms may come and go, and often get worse without therapy. Staff should report early warning signs of injury. Neither region routinely informs new staff about the signs and symptoms of back and shoulder injuries in their

orientation program. We saw no reminders about signs of common injuries on the units.

Orientation programs in both regions described risks that may contribute to injuries. In addition, the Occupational Health and Safety Regulations require that managers ensure there is a risk alert close to the risk area. A few units that we examined used a placard near each bed. The placard alerted staff to the risk of injury and told them how to lift that patient. Neither region consistently used this practice, although long-term care units were more likely to use them.

Patient care plans on the acute care units we examined seldom contained information about the appropriate lifting technique. The care staff relied on verbal messages from their co-workers to alert them to the risks in lifting specific patients.

Teach staff to eliminate hazards and avoid unnecessary risk

Both regions use best practices to teach staff to reduce or eliminate hazards. The training programs explain theory in classroom settings, including how to identify and eliminate risks related to lifting patients. Both regions provided adequate supervised practice either in model work units or on the staff member's own work unit. Saskatoon Health Region uses the provincial Transfer-Lift-Reposition Program to educate their staff. The Regina Qu'Appelle Health Region uses a Back Management Program.

Initial training programs for new staff are timely in both regions. We did not find evidence that the regions repeated training sufficiently often to remind all care staff of correct techniques. The Regina Qu'Appelle Health Region has placed its Back Management training program on its intranet and all staff have access while at work.

Managers promote risk reduction

In both regions, managers promote risk reduction. Unit managers encourage teamwork to reduce the risk of injury. For example, one manager puts up a reminder to use two-person lifts at eye level in hallways. Another manager asks about lifting techniques for specific patients during the change-of-shift report.

Unit managers informally encouraged warm-up exercises before work and use of equipment to reduce injuries. Both regions store available equipment for convenient use.

Managers in both regions knew about the individual injuries on their unit. None of the managers we interviewed knew the rate of injuries on their unit to help them assess progress over time. During 2002, unit managers did not receive summary reports analyzing their rate of injuries by type compared to injury rates in similar units, their facility, or their region. Managers who know the rate of injuries on their unit may be more likely to promote risk reduction.

Show commitment to reduce injuries

We expected a commitment to reduce the prevalence of injuries through the emphasis of safety and injury prevention in the workplace. We also expected support of injured care staff for a safe return to work to reduce the risk of re-injury. As part of the commitment to reduce injuries, we expected regions to monitor compliance with policies and agency-wide trends of hazards, incidents, and injuries. The Occupational Health and Safety Regulations require active occupational health committees, prompt reports and investigation of incidents, and reduced hours or duties to help workers return to work after injuries.

Emphasize workplace safety

Our audit found both Regina Qu'Appelle and Saskatoon Health Regions had occupational health committees in every facility as required by law. Both regions also had central coordinating committees that met at least twice yearly. All committees keep meeting minutes. The members of these committees represent both management and unions. Thus, the committees create a useful union-manager forum that both regions use to resolve specific safety concerns.

These occupational health committees dealt with issues such as smoking, infections, chemicals, and exposure to blood. None of these committees regularly paid attention to hazards in units that had consistently high injury rates. The committees did not have a system to record in their minutes those hazards that management had not fixed.

In the Saskatoon Health Region, annual evaluations of managers use a framework that includes the manager's responsibility for a healthy workplace. In the units we audited, general managers who supervise unit managers did not consistently promote safety during manager evaluations. The Regina Qu'Appelle Health Region does not include safety issues when evaluating managers' performance.

In these two health regions, neither the board nor senior managers communicated clearly to staff that safety or injury reduction is a priority. For example, in one region, all staff received a letter about smoking outside the hospital door, but we saw no evidence of any letter, poster, or newsletter about safety. We found no evidence of communication to staff in either region about taking action personally to reduce back and shoulder injuries. Reducing injuries requires communication and partnership approaches that emphasize workplace safety.

Enable early return to work

Both health regions had strong programs and policies that encouraged prompt therapy and an early return to work after injuries. In both regions, the programs allow injured staff to return to lighter duties or shorter hours.

When care staff return to work after injuries, if necessary, both regions employ an extra staff member on the same shift. This best practice enables a smooth return to regular work that reduces the risk of further injury.

Monitor compliance with policies

Policies in both health regions required maximum use of equipment to reduce injuries. Unit managers in both regions told us that they did not routinely monitor whether their staff used mechanical aids and correct techniques to lift and reposition patients. Saskatoon Health Region has begun to use coach-auditors to monitor staff use of practices that reduce injuries. The Region has a checklist that sets out what to look for when monitoring. The Region told us it began to use this best practice in 2003.

Policies in both health regions required prompt reports of incidents and injuries. The consistency of reporting varied. A few unit managers told us that their staff reported every "near miss" incident and actual injury while

other managers thought their staff reported only incidents resulting in injury.

Regina Qu'Appelle Health Region uses best practice to investigate "near misses" and incidents. The Region uses a one-page form that is concise, but covers the major factors that contribute to injuries in the workplace (e.g., environment, equipment, staff, patient). The form guides managers to make a thorough investigation at the time of the incident. It also provides guidance in looking for ways to prevent future injuries.

In the Saskatoon Health Region, unit managers did not use a written guide to investigate incidents. These managers informally investigated incidents on their unit by talking to staff. They did not consistently document factors that caused injuries.

Monitor trends across region

Neither health region had a formal process to routinely monitor injury trends across the region and analyze workplace hazards, "near miss" incidents, or injuries. Both regions have a system to produce a monthly listing of all reported incidents. These reports are given to senior management and the occupational health committees.

Neither senior managers nor the boards received summary reports that explained which units had a major injury problem and the factors that contributed to the problem on each unit. Neither region was aware of the total cost to each facility of injuries.

Both regions said that they plan to use new computer systems to create useful reports of injuries. Both regions intend to give at least annual reports to their boards at some future time.

Both regions collect information to monitor the number of injuries per 100 full-time care staff. This statistic is comparable across the country and should allow the regions to monitor their progress compared to similar facilities or regions.

In 2002, both regions gave the SAHO quarterly incident reports of time-loss injuries to senior managers and occupational health committees. These reports describe injuries severe enough that staff must seek

medical attention and take time off work. The SAHO reports show the severity and frequency of injuries for each hospital, long-term care centre, or home care service area. The reports compare the injury rate in the current quarter to the rate in the same quarter for the previous year. They do not show trends over the long term. Regina Qu'Appelle Health Region also gives this report to board members. Unfortunately, SAHO told us the reports may not be comparable and regions should use them only for analysis within each region. SAHO told us it is working to correct this problem.

Neither the Regina Qu'Appelle Health Region board nor the Saskatoon Health Region board uses targets to help monitor injury trends. Targets could be set for the region, facilities, or units to reduce workplace injuries. Without targets, managers do not know how much change the board expects them to achieve or by when. A few managers in both regions said they think there should be no injuries, in spite of the current high rate of injuries (i.e., over 10% of staff annually). Realistic targets are more inspiring and useful to monitor success.

Workplace safety a priority

Both Regina Qu'Appelle Health Region and the Saskatoon Health Region actively search for ways to improve the health and safety of all workers. Senior managers in both regions stated that re-organization of the health system limited their ability to focus on reducing injuries during 2002. Unit managers in both regions expressed frustration that their efforts have not resulted in consistently fewer injuries.

Board members and managers are accountable for work-related injuries. Senior leadership is essential to promote the use of best practices to reduce the prevalence of work-related back and shoulder injuries to care staff. Each individual staff member also has an important role to reduce the prevalence of back and shoulder injuries in the health sector.

Often those situations that put care staff at risk of injury also create risks for patients. We encourage decision-makers in the health system to make safety a priority.

We thank the managers of the Regina Qu'Appelle and Saskatoon Health Regions for their excellent cooperation throughout this audit. Without their

assistance, the effective completion of this audit would not have been possible.

Management response

The Saskatoon Health Region states that:

> The Saskatoon Health Region is concerned about the level of injuries to employees and has put in place a number of significant initiatives to assist us in reducing injuries to care staff. Most notably, we have begun implementing a Transfers, Lifting and Repositioning Program (TLR) which trains care staff in using mechanical aids to their greatest advantage, to minimize the amount of human effort in moving patients/clients. With the purchase of $100,000 of equipment last year, we are ensuring that adequate mechanical equipment is available to care staff. To achieve sustainability, we have incorporated the role of TLR auditor/coach. This person assists managers and employees on the units to address issues that arise, so they can continue to work safely over the long term.
>
> Additionally, we will increase our emphasis in the following areas. Beginning in 2003 – 04 the Saskatoon Health Region will increase the amount and type of injury trend analysis it undertakes. This analysis will be provided to senior leadership on a regular basis. Through the Region's performance management program, all Managers will be accountable for injury reduction in their areas. Additionally, the Occupational Health Committees will monitor injury trends and make recommendations to senior leadership, where appropriate. The Region will also begin monitoring staffing patterns for any potential impact on injury trends.

The Regina Qu'Appelle Health Region states that:

> The Regina Qu'Appelle Regional Health Authority remains committed to a positive and healthy work environment. The on-going achievement of this goal requires that workplace safety continue to be a high priority of the Health Region. The four specific sub-recommendations [of recommendation 1] outlined are all ones that currently fall within the expectations the Authority has for administration for 2003-2004 and subsequent years.
>
> Beginning in 2003-2004, the Regina Qu'Appelle Health Region will monitor staffing patterns to assess whether there are injury trends associated with them. This monitoring will necessarily include observations on the requirements imposed on the employer by various collective agreements.

> The valuable work of the [Occupational Health and Safety] committees will continue. Injury trends and their causes will be monitored. More importantly, the committees will be encouraged to make written recommendations to senior management to implement prevention initiatives and make safe practices a required daily standard.

Board of Governors, Uranium City Hospital

Order in Council #508/95 dated June 5, 1995 set up the Board of Governors, Uranium City Hospital (Hospital). The Department has informed us that the Government plans to close the Hospital during 2003. The Department is making plans for the Hospital's closure including the transfer of certain Hospital assets and staff to the Athabasca Health Authority (AHA). We think that our recommendations for the Hospital will be useful guidance to AHA's directors in their governance of AHA.

For the year ended March 31, 2002, the Hospital had revenues of $1.8 million, expenses of $1.5 million, and held assets of $0.7 million.

Our audit conclusions and findings

In our opinion, for the year ended March 31, 2002:

- **the Hospital's financial statements are reliable;**
- **the Hospital did not have adequate rules and procedures to safeguard and control its assets as reported in this chapter; and**
- **the Hospital complied with the authorities governing its activities relating to financial reporting, safeguarding assets, revenue raising, spending, borrowing, and investing except for the matters reported in this chapter.**

Board needs to carry out its duties

The Board is responsible to oversee the management of the Hospital's operations. To do this, the Board needs to set strategic and operating direction and monitor management's performance. Effective management is important for agencies to achieve their objectives.

Budget and operating plans need to be approved

In our 2000 Spring Report, we recommended that the Board approve a strategic plan and an operating budget before the year begins. In June 2001, the Standing Committee on Public Accounts (PAC) considered this matter and agreed with our recommendation.

The Board should approve a strategic plan and a budget to reflect the plan before the start of each fiscal year. Approving the plan and the budget is crucial to the Board in fulfilling its governance responsibilities. The Board must provide clear direction to the Chief Executive Officer (CEO) by approving a strategic plan and a budget that reflects the plan. Then, the Board must monitor the CEO's performance in achieving the plan.

The Board has not approved a strategic plan that sets out the goals and objectives for the health services provided by the Hospital. Also, the Board did not approve the Hospital's budget before April 1, 2002, the start of the fiscal year. Management prepared the budget in June 2002 and Board approved it in September 2002. This was a significant improvement over the previous year when the budget was prepared in October 2001 and approved by the Board in January 2002.

We continue to recommend that the Board of Governors, Uranium City Hospital, approve a strategic plan and an operating budget to reflect the plan before the start of the next fiscal year.

Senior management positions require contracts

In our 2001 Fall Report – Volume 2, we recommend that the Board prepare and approve adequate contracts for the CEO and Chief Financial Officer (CFO). In February 2002, PAC considered this matter and agreed with our recommendation.

The Board has now signed a contract with the CFO outlining his responsibilities to the Hospital. We reviewed the contract and found it to be adequate.

The CEO also has a contract, but it only addresses pay. The contract does not address the services the CEO is to provide. Without an

adequate contract, it is difficult for the Board to hold the CEO accountable for carrying out his responsibilities and to assess his performance.

We continue to recommend that the Board of Governors, Uranium City Hospital, prepare and approve an adequate contract for the Chief Executive Officer.

The Board needs to define required periodic financial information

In our 1998 Fall Report – Volume 2, we recommended that the Board, with the help of senior management, define and document the Board's financial reporting requirements. These requirements should ensure that the Board receives suitable and timely financial reports for decision-making. In June 2001, PAC agreed with our recommendation.

To date, the Board has not formally set out its reporting requirements.

We continue to recommend that the Board of Governors, Uranium City Hospital, with the help of senior management, define and document its financial reporting requirements.

Financial reports for the Board need improvement

In our 1998 Fall Report – Volume 2, we recommend that the Board improve its internal financial reports. In June 2001, PAC agreed with our recommendation.

The Board has made improvements to its internal financial reports. Management now prepares the reports in accordance with Canadian generally accepted accounting principles and include comparisons to prior years. However, these reports need further improvement to ensure the Board receives suitable and timely financial reports for decision-making.

The financial reports should include written explanations of major differences between year-to-date planned and actual results. This written analysis would help the Board fulfill its oversight role. Presenting the written explanations in advance of meetings makes it easier for Board members to analyze, evaluate, and monitor results. The interim financial

reports should include projections of revenues and expenses to the end of the year based on current information.

We continue to recommend that the Board of Governors, Uranium City Hospital improve its financial reports to include:

- written explanations of major differences between year-to-date planned and actual results; and
- projections of revenue and expenses to the end of the year based on current information.

Management told us that they present verbal explanations of differences and year-end projections to the Board.

Adequate rules and procedures required

For the Board to adequately manage and control the Hospital, the CEO must establish adequate written rules and procedures to achieve the Hospital's objectives and to safeguard the Hospital's assets.

Written rules and procedures provide for the orderly and efficient conduct of business. They help ensure goods and services purchased are:

- authorized and appropriate;
- received and used for the operation and management of the Hospital;
- physically secured; and
- priced fairly.

Rules and procedures also reinforce the Board's delegation of authority and the responsibilities of all employees. Adequate written rules and procedures help reduce the risk of errors, fraud, breakdowns in control, and unauthorized transactions.

In the following paragraphs, we set out examples of where the Hospital's rules and procedures were not adequate to safeguard the Hospital's

assets. The rules and procedures were inadequate because they were either not in place or they were not functioning properly. As a result, we were unable to determine if all payments made by the Hospital were for the benefit of the Hospital.

Bank account not controlled

In our 2000 Spring Report, we recommended that the Board strengthen its rules and procedures to safeguard and control its bank account. In June 2001, PAC considered these matters and agreed with our recommendation.

The Hospital continued to lack adequate procedures for ensuring that it pays employees accurately and only for work performed. Employees documented their hours of work, but no one approved the hours worked. This lack of approval increases the risk that the Hospital may pay for work not done. As a result, we were unable to determine if all of the salaries and benefits paid to employees were for services provided to the Hospital.

In addition, management did not follow up on possible errors in employees pay. We discovered many small errors indicating that the hospital may have overpaid some employees and underpaid others. Management was aware of these errors but did not determine why the errors occurred. To ensure the Hospital pays employees correctly, management should investigate and correct these errors.

In addition, the Hospital had inadequate controls for paying suppliers of goods and services. The Hospital did not always authorize payments. Cheque signers did not always review the suppliers' invoices before signing the cheques for payment. Therefore, no one checked to ensure that the Hospital's money was being spent only on goods and services for the benefit of the Hospital. In addition, we were unable to determine if all of the goods and services purchased by the Hospital were for the benefit of the Hospital.

We continue to recommend that the Board of Governors, Uranium City Hospital, strengthen its rules and procedures to safeguard and control its bank account.

Assessment of contracts required

In our 2001 Fall Report – Volume 2, we recommended that the Board obtain a ruling from Canada Customs and Revenue Agency (CCRA) for all its contract workers. The Board must determine whether an employer-employee relationship exists with its contract workers to ensure it makes the correct deductions. In February 2002, PAC considered this matter and agreed with our recommendation.

The Hospital had fifteen contract workers during 2002-03. It paid these workers a total of $380,000. The CCRA has guidance for determining whether an employer-employee relationship exists. The rules for Canada Pension Plan, employment insurance, and income tax deductions and contributions are different if an employer-employee relationship exists.

The Hospital continues to think that an employer-employee relationship with its contract workers does not exist. So, it does not make deductions from its contract workers' pay for Canada Pension Plan, employment insurance, and income tax. Also, it does not contribute the employer's portion of the Canada pension plan and employment insurance to CCRA for these contract workers.

In 2001, the Hospital received a ruling from CCRA for one of its 15 contract workers. CCRA found that an employer-employee relationship exists with that person and the Hospital owed CCRA approximately $3,600 in retroactive contributions for that person. The Hospital is appealing this ruling.

When the Hospital receives a final ruling in this case, it must decide if the findings apply to its other fourteen contract workers. The Hospital may be subject to penalties and retroactive contributions if an employer-employee relationship exists with these other contract workers.

Because the Hospital has not obtained a final ruling from CCRA on whether an employer-employee relationship exists with that worker or for its other contract workers, we are unable to determine if the Hospital is complying with CCRA's requirements.

We continue to recommend that the Board of Governors, Uranium City Hospital obtain a ruling from Canada Customs and Revenue Agency for

all its contract workers to determine whether an employer-employee relationship exists with its contract workers and then take deductions accordingly.

External reporting requirements not met

In our 2001 Fall Report – Volume 2, we recommended that the Board give its financial statements to the Legislative Assembly by the date required by *The Tabling of Documents Act, 1991.* In February 2002, PAC considered this matter and agreed with our recommendation.

For the year ended March 31, 2002, the Board did not give its financial statements or a report on the Hospital's activities to the Assembly by August 31, 2002, the date required by the Act. The Board gave its financial statements to the Assembly on December 17, 2002, but has not given the Assembly a report on the Hospital's activities.

We continue to recommend that the Board of Governors, Uranium City Hospital give its financial statements to the Legislative Assembly by the date required by *The Tabling of Documents Act, 1991*.

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