Hand Hygiene

1. Introduction

Description

The purpose of this policy is to help protect patients/clients/residents ("Patients"), Healthcare Providers, and visitors from transmitting and/or acquiring hospital associated infections. Hand hygiene is universally accepted as the single most important method for infection prevention and control.

Scope

This policy applies to all Vancouver Coastal Health (VCH) Healthcare Providers including contracted services personnel, physicians and students.

2. Policy

VCH expects every Healthcare Provider to clean their hands before and after touching any Patient and/or the Patient environment. Specifically, Healthcare Providers will perform hand hygiene:

BEFORE:

- Touching a Patient
- Touching any object or furniture in the Patient's environment
- Putting on gloves
- Performing any aseptic procedure
- Handling medication and food
- Risk of exposure to blood/body fluids

AFTER:

- Touching a patient
- Touching any object or furniture in the patient's environment
- Removing gloves
- Performing any aseptic procedure
- Handling medication and food
- Exposure risk to blood/body fluids

Healthcare Providers are expected to comply with this policy in 100% of non-emergent situations.

Healthcare Providers may be required to forgo hand hygiene during emergent Patient situations, e.g. Patient collapse. In emergent situations Healthcare Providers are encouraged to perform appropriate hand hygiene as soon as possible after the Patient has been stabilized.

Healthcare Providers who are unable to perform hand hygiene due to injury or skin conditions, e.g. eczema or psoriasis, must report to the Occupational Health Nurse immediately for consultation.

2.1. Methods for Hand Hygiene

Alcohol Based Hand Rub (ABHR) is the preferred method for performing hand hygiene in healthcare settings.

Soap and water are used for hand hygiene when hands are visibly soiled and in exceptional situations, such as interacting with Patients with Clostridium difficile ("C. Diff"), and other spore forming bacteria. If a sink is not immediately available, hand hygiene will be performed with ABHR immediately after Patient care. Hand washing with soap and water will be performed as soon as possible after this.

2.2. Glove Use

The use of gloves is an integral component of Universal Precautions. The use of gloves is not a substitute for performing hand hygiene. Gloves must be changed between each Patient contact and care procedure, e.g. between bathing and mouth care on the same Patient. Hand hygiene must be performed before and after using gloves.

2.3. Special Considerations

Healthcare providers will keep nails clean and short at all times. Long and/or chipped nails are known to harbor bacteria and interfere with effective hand hygiene.

Healthcare providers will not have artificial nails and nail jewelry.

Healthcare providers should not wear hand/wrist jewelry. Jewelry hinders effective hand hygiene and harbors the growth of bacteria.

2.4. Patient and Visitor Hand Hygiene

All Healthcare Providers will promote Patient hand hygiene to assist in reducing the spread of infection. Healthcare Providers will provide Patients with educational guidance and support to perform hand hygiene. Patients who are immobile, bed bound, and/or confused may require frequent support from Healthcare Providers to assist with hand hygiene either with soap and water or alcohol based hand rub (ABHR).

Healthcare Providers will provide Patients and visitors with educational guidance and support to adhere to the hand hygiene policy.

2.5. Education

All Healthcare Providers must take hand hygiene basics module through CCRS once every 2 years.

2.6. Responsibilities

2.6.1. Healthcare Providers

All Healthcare Providers are responsible for their own hand hygiene practices and to educate patients and visitors on the importance of hand hygiene.

2.6.2. Hand Hygiene Team/Infection Control

The regional hand hygiene program is responsible for auditing Healthcare Provider hand hygiene compliance. The regional hand hygiene program and infection control are responsible for staff, patient, visitor hand hygiene education.

2.7. Compliance

Hand hygiene compliance audits take place monthly for all Healthcare Providers throughout VCH. Audits help monitor Healthcare Provider compliance of hand hygiene before and after direct contact with the Patient and/or the Patient environment.

Any Healthcare Provider found in violation of this policy will be reminded and with repeated non-compliance may be subject to remedial or disciplinary action up to and including termination of employment, cancellation of contract, and/or revocation of privileges pursuant to applicable VCH processes.

Any Healthcare Provider, including contracted services employees, may report persistent violations of compliance to the VCH Safety Centre by calling 1-877-875-5757. No Healthcare Provider will be subject to retaliation for reporting in good faith breaches of this hand hygiene policy.

Healthcare Providers are encouraged to remind visitors and Patients to follow the Hand Hygiene policies.

3. References

Tools, Forms and Guidelines

- 4 Moments for Hand Hygiene
- How to handwash
- How to handrub

Related Policies

- Mandatory Education
- Occupational Health and Safety
- Standards of Conduct, Conflict of Interest, and Whistleblowing Protection

Keywords

Hand hygiene, wash, soap, sanitize, C. diff, infection, alcohol based hand rub, communicable disease, patient handling

Definitions

"**ABHR**" means Alcohol Based Hand Rub

"**Patient**" means any patient, client or resident receiving care or services from Vancouver Coastal Health.

"**Healthcare Providers**" means all employees (including management and leadership), Medical Healthcare Providers Members (including physicians, midwives, dentists and Nurse Practitioners), residents, fellows and trainees, students, volunteers, contractors and other service providers engaged by VCH having direct contact with Patients or their immediate environment.

"Universal Precautions" a set of precautions designed to prevent transmission of HIV, hepatitis B virus (HBV), and other bloodborne pathogens when providing first aid or health care. Under universal precautions, blood and certain body fluids of all patients are considered potentially infectious for HIV, HBV and other bloodborne pathogens

Questions

Contact: Coordinator, Hand Hygiene Program (Sheila.Browning@vch.ca)

Issued by:

Name: **Patrick O'Connor** Title: VP, Medicine, Quality & Safety Date: March 25, 2014

Signature of issuing official

Information Privacy & Confidentiality

1. Introduction

Description

Vancouver Coastal Health Authority ("VCH") has ethical and legal obligations to protect Personal Information about its Clients and Staff. VCH may also be obliged under contract or other circumstances to protect Confidential Information.

The purpose of this Information Privacy & Confidentiality Policy ("Policy") is to establish the guiding principles and framework by which VCH and its Staff will comply with these obligations, demonstrate accountability for managing Personal Information and Confidential Information and maintain its trust-based relationship with Clients, Staff, business and healthcare partners (including Lower Mainland Consolidation parties) and the public.

Scope

This Policy applies to all Staff and all Personal Information and Confidential Information in the custody or control of VCH regardless of format and how it is stored or recorded.

2. Policy

2.1. Privacy legislation and Policies

VCH and its Staff are governed by the *B.C. Freedom of Information and Protection of Privacy Act* ("FIPPA"), the *E-Health (Personal Health Information Access and Protection of Privacy) Act* and other legislation, professional codes of ethics and standards of practice.

VCH will comply with FIPPA when collecting, using and disclosing Personal Information.

All Staff must ensure that their practices in collecting, accessing, using or disclosing Personal Information and Confidential Information comply with this Policy as well as applicable laws, professional codes of practice and contractual obligations. These obligations for ensuring privacy and confidentiality continue after the employment, contract or other affiliation between VCH and its Staff comes to an end.

2.2. Confidentiality Undertaking

All Staff must complete the VCH Confidentiality Undertaking and Information Privacy Online course as required by the *Mandatory Education* Policy.

2.3. Collection of Personal Information

Staff may collect Personal Information as needed to operate VCH programs or activities and will not collect more Personal Information than is required to fulfill those purposes.

2.4. Direct Collection

Where possible, VCH will collect Personal Information directly from the individual the information is about.

When Staff collects Personal Information directly from an individual, the individual should be informed of:

- the purpose for the collection;
- the legal authority for the collection; and
- the contact person if the individual has any questions about the collection.

VCH uses the VCH Client Notification Sign and other materials to inform Clients of the above. Notification Signs should be posted at all registration, intake and admission sites, including community centers and clinics.

2.5. Indirect Collection

Staff may collect Personal Information indirectly (from sources other than the Client):

- with the consent of the Client;
- where the information is required to provide health care and it is not possible to collect the information directly from the Client (Client consent is not required);
- where another public body is authorized to disclose the information to VCH; or
- as otherwise permitted by FIPPA

For example, where the Client is incapable of providing information or does not have the information, Staff may collect Personal Information necessary to provide care from another Health Authority, other health care providers, family members or friends.

2.6. Accuracy of Personal Information

VCH and its Staff will take all reasonable steps to ensure the accuracy and completeness of any Personal Information VCH collects or records. Staff will exercise diligence to protect against errors due to carelessness or oversight.

Health Information Management (Health Records) is responsible for updating and maintaining the accuracy of health records of Clients. Staff should direct any Clients requesting correction or amendment of information in their medical records to Health Information Management.

2.7. Use of Personal Information

Staff may only access and use Personal Information for legitimate purposes based on a "need to know" in order to perform job functions and responsibilities.

Primary Use

VCH primarily collects Personal Information about Clients to provide health care services to Clients. Staff may use Personal Information for the provision of care to Clients and for administrative and other support functions related to direct care.

Secondary Use

Staff may use Personal Information for purposes related to the provision of care ("Secondary Purposes") only if the purpose has a reasonable and direct connection to the provision of health care services and is required for an operating program of VCH. For example, Staff may use Client Personal Information for the following Secondary Purposes:

- program planning, evaluation and monitoring, including quality improvement;
- system administration;
- privacy and security audits;
- medical education and training related to VCH programs;
- analysis, management and control of disease outbreaks and population health; and
- as otherwise authorized by FIPPA.

Client identifying information is not always required where information is used for Secondary Purposes. As a general rule, Staff should only use Personal Information that is necessary to achieve the Secondary Purposes. Where possible, personal identifiers (e.g., name, birth date, photograph, PHN, MRN, home address, postal code, personal telephone number, social insurance number, driver's license number, employee ID number, and other identity numbers) should be removed from records and documents, such as statistical management reports or sample electronic health records used for system usage training.

Research

Staff may use Personal Information for research only in compliance with VCH policies and procedures related to research, including approval from the VCH Research Institute and the Information Privacy Office, and any Research Ethics Board conditions.

2.8. Disclosure of Personal Information

Set out below are examples where Personal Information may be disclosed. Staff may consult with the Information Privacy Office for questions about disclosure.

Disclosure for Continuity of Care

Staff may disclose Personal Information on a "need-to-know" basis to other health care providers or members of the care team, both within and outside VCH, including to family members who are providing care (i.e., within the "circle of care" or for "continuity of care"). Disclosures within the circle of care do not require consent, although Staff may wish to discuss such disclosures with the Client.

Disclosure for Safety Purposes

Staff may, without requiring Client consent, disclose Personal Information necessary to provide warning or to avert the risk:

- where compelling circumstances exist that affect the health or safety any person;

- to protect the public in circumstances where there is a risk of significant harm to the environment or to the health or safety of the public or a group of people; or
- to reduce the risk that anyone will be a victim of domestic violence, if Staff believe that domestic violence is reasonably likely to occur.

Staff should seek approval from a Staff member in charge, supervisor or manager. If in doubt Staff should consult with the Information Privacy Office or Client Relations and Risk Management in deciding whether to disclose information. Examples of compelling circumstances include:

- an intent expressed by the Client, which Staff believe, to cause serious harm to self or others, such as specific threats of assault or death; and
- a Client who is incapable of driving and indicates intention to drive.

Good-faith decision-making

VCH will not dismiss, suspend, demote, discipline or otherwise disadvantage a Staff member who, acting in good faith and upon a reasonable belief, discloses Personal Information necessary to provide warning or to avert risk where immediate action is required to prevent harm to any person's health or safety.

Disclosure to Law Enforcement

For disclosures of Personal Information to law enforcement (e.g., mandatory demands such as court orders or search warrants, requests by law enforcement, or VCH-initiated reporting to law enforcement) see the *Release of Information or Belongings to Law Enforcement* Policy.

Disclosure with Consent

Besides the disclosures described above and other disclosures authorized by FIPPA, Staff may disclose Personal Information with Client consent. Client consent should be in writing or may be documented by Staff on the health record.

Disclosures Outside of Canada

Staff will not access, transfer or store Personal Information outside of Canada, except with the consent of the individual the information is about or as otherwise permitted by FIPPA (eg. while temporarily travelling outside Canada, or temporary access for systems support). Staff will consult the Information Privacy Office before implementing a program where Personal Information will be transferred, stored or accessed from outside of Canada.

Obligation to Report Foreign Demand

Staff who receive or learn of a foreign demand for the disclosure of Personal Information or about the unauthorized disclosure of Personal Information in response to a foreign demand must report it to Legal Services. "Foreign demands" include subpoenas, warrants, orders or requests from courts or agencies outside Canada.

Requirements for Third Party Access to Personal Information

Where Personal Information is shared with, accessed or stored by a third party vendor, contractor, agency or other organization, a written agreement or other legal documentation may be required. Staff must consult with Legal Services or the Information Privacy Office to determine what documentation is required. Examples where legal documentation may be required are as follows:

- access by a third party organization to VCH clinical information systems
- services provided by a vendor who will have access to Personal Information
- program that requires Personal Information to be shared with another agency

Personal Information may be disclosed to third parties for research only in compliance with VCH policies and procedures related to research, including approval from the VCH Research Institute and the Information Privacy Office, the requirement to sign an Information Sharing Agreement and Research Ethics Board approval.

Release of Information Requests

Health Records: Staff may provide Client with a copy of a document if it was completed with the Client present (e.g. client assessment, care plan). Staff may also provide Client with a copy of a single lab or radiology report if they request. If Client requests a copy of their entire health record or health records narrative in nature (e.g. progress notes, transcribed reports), please direct the request to Health Information Management (Health Records Department).

Corporate/Non-Health Records: Refer requests to the Freedom of Information Office.

Employee Information

Requests for employee information from legal firms, financial institutions, insurance companies, credit bureaus, etc. should be directed to Employee Engagement/Payroll.

2.9. Safeguards

VCH must take reasonable security precautions to protect Personal Information and Confidential Information against unauthorized access, collection, use, disclosure or disposal. Personal Information must be protected by appropriate safeguards according to the sensitivity of the information, regardless of the format in which it is held.

Physical Measures and Safeguards

Staff will comply with VCH physical security requirements and will take all reasonable steps to protect Personal Information and Confidential Information against unauthorized access, collection, use, disclosure or disposal, including:

- keeping hard copies of files and records containing Personal Information or Confidential Information in a secure location, such as locked storage rooms or locked filing cabinets, with controls over distribution of keys or lock combinations;

- protecting mobile electronic devices and storage media containing Personal Information or Confidential Information against theft, loss or unauthorized access;
- using available security systems (e.g., locking offices when not in use, activating alarm systems);
- refraining from disclosing and discussing Personal Information or Confidential Information in public areas where third parties may overhear or view records containing Personal Information or Confidential Information;
- following VCH guidelines and procedures for the secure destruction or disposal of Personal Information or Confidential Information that is no longer required to ensure the Personal Information or Confidential Information is destroyed, erased or made anonymous;
- prohibiting removal of records containing Personal Information or Confidential Information from VCH premises except as necessary, and, in such cases ensuring they are kept in a secure location and not exposed to risk of loss, theft or unauthorized access.

Technical Measures and Safeguards

Staff will comply with VCH technical security requirements and will take all reasonable steps to maintain the integrity of electronic systems, including:

- protecting the integrity of passwords, user-id's and other security access measures;
- logging-off computers when not in attendance;
- using encryption and password protection for mobile electronic devices and storage media.

2.10. Privacy Impact Assessment

A Privacy Impact Assessment ("PIA") must be completed before implementing or significantly changing any program or system that requires the collection, use, disclosure or sharing of Personal Information.

Before undertaking any new initiative, program or activity that involves Personal Information, VCH departments must contact the Information Privacy Office to determine whether a PIA is required. Completion of a PIA is the responsibility of the department undertaking the program or activity, with support from the Information Privacy Office.

2.11. Privacy Training

VCH will ensure that Staff who manage, access or use Personal Information receive privacy and information management training when initially hired and as required on an ongoing basis. The Information Privacy Office will develop privacy education programs in conjunction with Employee Engagement and other operational areas to educate all Staff and users of Personal Information about VCH's privacy obligations.

2.12. Retention of Personal Information

VCH must retain for a minimum of one year Personal Information that is used to make a decision that directly affects the individual the information is about. Currently, VCH retains health records for longer periods to comply with Ministry of Health directives.

Staff and their respective departments must adhere to regional or departmental policies on the retention of records containing non-health-related Personal Information.

2.13. Whistleblower Protection

VCH will not dismiss, suspend, demote, discipline, harass or otherwise disadvantage a Staff member who, acting in good faith and upon a reasonable belief, has done or intends to do the following:

- make a report to the appropriate authority about a foreign demand for Personal Information;
- disclose to the BC Office of the Information and Privacy Commissioner that VCH or another individual has contravened FIPPA;
- do something required to avoid contravention of FIPPA or refuse to contravene FIPPA; or
- inform VCH about a breach of or violation of this Policy.

2.14. Challenging Compliance

The Information Privacy Office will investigate all complaints concerning compliance with this Policy, and, if a complaint is found to be justified, will take appropriate measures including amending policies and procedures where required. The complainant will be informed of the outcome of the investigation regarding the complaint.

2.15. Reporting Privacy Breaches

Staff must immediately report to the Information Privacy Office any actual or suspected Privacy Breaches or violations of this Policy, including the theft or loss of Personal Information, devices or paper records. Privacy Breaches will be dealt with in accordance with the *Reporting and Management of Information Privacy Breaches* Policy.

2.16. Responsibilities

2.16.1. Chief Executive Officer / Senior Executive Team / Chief Privacy Officer

The Chief Executive Officer of VCH is the appointed head of VCH for the purposes of exercising the powers of the head and ensuring compliance with FIPPA. The authority of the head is delegated to the members of the Senior Executive Team and to the Chief Privacy Officer.

2.16.2. Information Privacy Office / Legal Services

The Information Privacy Office / Legal Services is responsible for:

- general oversight of privacy practices and policies within VCH;
- providing privacy education to Staff and promoting good privacy practices throughout the organization;
- responding to questions from Staff, Clients, and members of the public concerning collection, access, use and disclosure of Personal Information;
- investigating potential and actual breaches of this Policy brought to its attention and reporting Privacy Breaches in accordance with VCH breach policies.

2.16.3. Employee Engagement

Employee Engagement is responsible for:

- in consultation with the Information Privacy Office, developing and maintaining policies in respect of disciplinary actions to be taken for Staff who have been determined to have breached this Policy;
- cooperating with and assisting in Information Privacy Office investigations into compliance with this Policy; and
- in consultation with the Information Privacy Office, ensuring that disciplinary action for a breach of this Policy or FIPPA is carried out in accordance with Employee Engagement policies.

2.16.4. Staff

All Staff who have access to Personal Information or Confidential Information are responsible for complying with this Policy and FIPPA. Staff are required to:

- ensure that access to and disclosure of Personal Information or Confidential Information is only made by or to authorized individuals;
- ensure that reasonable measures are taken to prevent any unauthorized access, disclosure, loss or theft of information;
- comply with terms of use and security requirements for electronic systems;
- report to the Information Privacy Office any actual or suspected Breaches of privacy or this Policy and cooperate with the Information Privacy Office and Employee Engagement for the purposes of any investigation.

2.17. Compliance

Failure to comply with this Policy may result in disciplinary action including, but not limited to, the termination of employment, the termination of the contractual agreement, loss of computing privileges, loss of privileges as a student placement or volunteer role, prosecution and restitution for damages.

VCH will not take disciplinary action against a Staff member who, acting in good faith and upon a reasonable belief, discloses Personal Information necessary to provide warning or to avert risk where immediate action is required to prevent harm to any person's health or safety.

3. References

Tools, Forms and Guidelines

The Information Privacy Office webpage has a complete list of privacy-related policies, tools, forms and guidelines.

Keywords

Privacy, Breach, Confidentiality, Personal Information, Confidential Information, Freedom of Information and Protection of Privacy Act, FIPPA, Security, Lower Mainland Consolidation

Definitions

"**Clients**" means all people receiving care or services from VCH and includes patients and residents.

"**Confidential Information**" means all information, other than Personal Information, that is specifically identified as confidential or is reasonably understood to be of a confidential nature, that Staff receive or have access to through VCH or through other Lower Mainland Consolidation parties, including vendor contracts and other proprietary information that a Lower Mainland Consolidation party may have received from a third party.

"**FIPPA**" means the BC *Freedom of Information and Protection of Privacy Act*, as amended from time to time.

"**Lower Mainland Consolidation**" means the consolidation of certain corporate and clinical support functions amongst Vancouver Coastal Health Authority, Fraser Health Authority, Provincial Health Services Authority and Providence Health Care Society as more fully set out in a Master Services Agreement amongst the parties dated January 1, 2011.

"**Personal Information**" means any information about an identifiable individual, but does not include business contact information (eg. individual's title, business telephone number, business address, business email or facsimile number).

"**Privacy Breach**" or "**Breach**" occurs when there is unauthorized access to or collection, use, disclosure or disposal of Personal Information. Such activity is "unauthorized" if it occurs in contravention of Part 3 of the *Freedom of Information and Protection of Privacy Act*[1].

"**Staff**" means all employees (including management and leadership), Medical Staff Members (including physicians, midwives, dentists and Nurse Practitioners), residents, fellows and trainees, health care professionals, students, volunteers, contractors and other service providers engaged by VCH.

Questions

Contact: Information Privacy Office at privacy@vch.ca

Issued by:					
Name:	**Glen Copping**	Title:	CFO & VP, Systems Development & Performance	Date:	March 7, 2014
	Signature of issuing official				

[1] Privacy Breaches: Tools & Resources. Office of the Information & Privacy Commissioner for British Columbia. https://www.oipc.bc.ca/guidance-documents/1428 accessed March 2016.

Standards of Conduct

1. Introduction

Description

The purpose of this policy is to establish minimum standards of conduct for all Staff.

Vancouver Coastal Health (VCH) expects Staff to adhere to the highest standards of conduct with respect to ethical and professional behaviour.

VCH staff will refer to this Policy to provide them with guidance on appropriate conduct, in addition to any other professional code of ethics or standards of practice to which they are bound.

Scope

This policy applies to all Staff.

2. Policy

2.1. *Email Access*

Staff are responsible for being aware of VCH policies that govern their activities and behaviour (as may be created and updated by VCH from time to time) and must ensure compliance with such policies.

All non-medical staff will receive a VCH email account and are to access their account when they are at work at least once per week. Staff should notify their supervisor where they do not receive a minimum of 15 minutes of access to a computer during work time.

All Medical staff must provide VCH Medical Affairs with an email address and are to respond to the email address in a timely manner.

2.2. *Integrity & Conduct*

Staff will address their full attention during working hours to carry out their duties and responsibilities and to further the interests of VCH.

VCH will not tolerate the use of substance that affects job performance, behaviours, safety, and/or attendance. If an Employee is suspected of being impaired he/she will be removed from the workplace by a Manager to eliminate any safety risk to our patients, staff and the public. All VCH staff are responsible to report any unsafe work acts they observe to the Supervisor, who will investigate the concern.

Activities outside of work must not impact on a staff member's ability to perform his/her job during working hours.

Staff receiving paid sick leave from VCH must not work elsewhere without VCH approval. Approval will only be granted where medical proof, satisfactory to VCH, recommends the alternate employment as part of a treatment/rehabilitation program. Wages earned during the approved alternate employment shall be paid, upon receipt, to VCHA. The staff member's sick leave bank will be credited for the number of hours represented by the payment.

2.3. *Public Communication*

Staff must avoid representing the official position of VCH unless appropriate approval has been obtained from Communications and Public Affairs and/or senior management. Staff may respond to questions and queries from the public within their immediate duties and refer queries beyond their immediate duties to Communications and Public Affairs or to senior management.

Public Statements

- Staff making public statements on personal issues must not represent themselves as VCH staff.

Media Relations

- Written media releases on behalf of VCH, its programs or services are issued only by Communications and Public Affairs or the CEO, unless pre-authorized by Communications and Public Affairs.
- Calls from the media should be referred immediately to Communications and Public Affairs unless the inquiry is regarding technical or procedural matters.

Staff must report all media contact immediately to Communications and Public Affairs. Information that is available to the public can be provided to the media. However, all media inquiries should be discussed with the staff member's manager. Where there is uncertainty about the appropriateness of the response, Communications and Public Affairs must be notified before a response is given.

2.4. *Political Activity*

Staff must ensure that any political activity undertaken is clearly separated from activities related to their employment. Staff must not engage in political activities during working hours or use VCH facilities, equipment or resources in support of these activities.

2.5. *Misuse of VCH Property*

Staff require approval from their manager to use VCH property, including equipment, materials, and information for personal purposes.

Internet usage by Staff during work hours or on VCH owned computer equipment must be able to survive public scrutiny and/or disclosure. Staff must avoid accessing sites that could reasonably be expected to bring VCH into disrepute or negatively affect VCH's reputation in the community, including sites that display Offensive Material.

Staff must only use VCH communication tools, including computers and telephones, for legitimate business purposes. Staff may, from time to time, use communication tools for limited personal use which does not involve the reproduction, dissemination or handling of Offensive Material or is otherwise contrary to law or the employment obligations of the Staff member. If a communication tool is used for non-VCH purposes the employee will pay for any costs attributable to such use.

2.6. *Responsibilities*

2.6.1. Staff

Staff are responsible for complying with this Policy, and for any VCH policy that govern their activities and behaviour.

2.6.2. Management

Management is responsible for supervising Staff compliance with this Policy, and with any VCH policy that governs the activities and behaviour of Staff, within the scope of their responsibilities.

2.6.3. Employee Engagement

Employee engagement is responsible for the maintenance and operation of this Policy.

2.7. *Compliance*

The requirement to comply with these standards of conduct is a condition of employment. Employees who fail to comply with this policy may be subject to disciplinary action up to and including dismissal.

3. References

Tools, Forms and Guidelines

- None

Related Policies

- Conflict of Interest
- Information Privacy and Confidentiality
- Respectful Workplace and Human Rights
- Whistleblower
- Social Media, Websites and Online Communication

Keywords

Standards of Conduct, Integrity, Political Activity, Personal Use, Equipment, Communications, Media, Public, Employee Engagement

Definitions

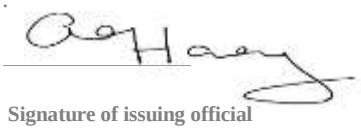
"**Staff**" means staff, employees, researchers, students, volunteers and medical staff who are engaged by VCH;

"**Offensive Material**" includes but is not limited to, pornography, hate literature or any material which contravenes the BC Human Rights Act;

Questions

Contact: Employee Engagement

Issued by:

Name:  Title: Vice President, Employee Engagement Date: May 25, 2015

Signature of issuing official

COMPLAINT MANAGEMENT POLICY

1. POLICY PURPOSE

A complaint is an expression of dissatisfaction when an expectation is not met. Although it may appear minor, it is a very real problem to the complainant and will be taken seriously.

The Ministry of Health Services requires health authorities to have written complaint handling policies and procedures to address client complaints about services delivered by a health authority or by a third party under contract to a health authority which:

- Respond to client complaints with a decision
- Conduct a review of that decision upon request
- Are accessible, customer focused and fair
- As an accountable, client-centered organization, it is important for Vancouver Coastal Health Authority (VCHA) to have an accessible method for people to bring their concerns to the attention of the health authority and have them addressed effectively in a way that supports staff and the people we serve. As a learning organization, we value this feedback to allow us to improve our care and service delivery processes.

2. POLICY STATEMENT

VCHA staff welcome, investigate and address all concerns or complaints, involving Patient/Client Relations staff for advice and support as warranted:

- If complaint involves a claim for reimbursement or compensation, refer to Patient/Client Relations. (*see "Procedure for Handling Small Claims- Appendix 4*)
- If staff member handling the complaint feels that resolution of the concern requires broader attention, contact Patient/Client Relations for discussion.
- If the complainant has retained legal counsel, alleges discrimination, or has police involvement, refer immediately to the Program Manager and Risk Management, in addition to Patient/Client Relations.

RESPONSIBILITIES

VCHA

- Ensures that there is a complaint management policy in place that is applicable to all services under its mandate and is consistent with the Ministry of Health Services policy.
- Ensures that the policy is implemented and there are systems in place to ensure that complaints are:
    - Responded to individually
    - Documented, tracked and monitored for trends
    - Used to identify and address program and system issues

- Ensures that the complaints management process is known and easily accessible by patients, clients, and the public.
- Receives reports on issues, risk, and trends.
- Ensures appropriate responses to identified system issues.

Health Service Delivery Areas (HSDA)

- Ensures the complaint policy is implemented and complaint management guidelines integrated into practice.
- Provides staff the appropriate information and training about this policy to ensure they are able to provide clients with the necessary information and help, where needed, in accessing the complaint mechanism.
- Documents and tracks all complaints received using a VCHA-wide system with common categories that provides reports for various levels in the organization for improvement activities.
- Investigates complaints and makes appropriate improvements/recommendations for improvements.
- If litigation, a claim, human rights complaint or media exposure is likely or if the severity rating is considered high, refer to Risk Management as well as Patient/Client Relations for consultation and assistance.
- Involves communication staff when media exposure likely.

VCHA staff, physicians, volunteers, and students

- Support people in accessing the complaint management mechanisms.
- Assist clients, where possible, to overcome barriers (e.g., physical, mental, emotional, cultural, language) they may experience in accessing the complaint process.
- Follow complaint management guideline and respond to complaints in a positive, fair, confidential and timely way. Are proactive in resolving issues, whenever possible, at source.
- Participate in complaint investigations as requested.
- Participate in improvement activities as appropriate.

3. POLICY SCOPE

This policy and guidelines relates to all directly provided VCHA services. Contract managers are expected to require contracted providers to develop a complaints management policy congruent with this VCHA policy.

4. POLICY PRINCIPLES

Complaint management is responsive to the needs of the population within the health authority and based on the following principles (*see Appendix 1 for definitions*):

Flexibility	Accessibility	Cultural Sensitivity
Consistency	Accountability	Timeliness
Administrative Fairness	Natural Justice	Local Resolution

5. PROCEDURES / GUIDELINES

ACCESS

People served by the VCHA, their families, advocates or observers are able to make a complaint verbally (in person or by phone) and/or in writing (by FAX, letter or email).

Complainants are encouraged to have their complaints resolved at the time and place they occur. Should they fail to find satisfaction at that level, they then have access to the next level of management. People are also welcome to take their complaints to the HSDA Patient/Client Relations staff for assistance in having them resolved.

People served by VCHA staff and services are made aware of the VCHA complaint management process in the following ways:

- Brochures or other written materials in languages representative of the population served (where available).
- In program information given to patients/clients as well as satisfaction surveys and other client feedback tools.
- Website (where available)
- Verbal information from staff, physicians, and students

COMPLAINT RECEIPT (INTAKE)

Staff, physician, student or volunteer

Hearing the Concerns:

- Demonstrate caring and concern through careful attention to details and response to questions that are presented.
- Show respect and genuine interest in the concerns being expressed.
- Establish a positive initial impression by greeting the person in a friendly, open manner.
- Validate the impact from the client's perspective.
- Use plain language to obtain the information.
- Assure complainant that confidentiality will be maintained as much as possible. Anonymous complaints will be addressed, however, in order to conduct a thorough investigation, concerns need to be shared with the appropriate manager.
- Ensure complainant's perspective is understood; offer the opportunity to put their perspective of the complaint in writing if appropriate.
- Whenever possible, be proactive in resolving the issue at source, involving practice consultants available in your service.

If the complaint cannot be resolved:

- Inform the individual that the documentation will be forwarded to the most appropriate designated staff person based on the nature of the complaint.
- Document the issues using the appropriate forms. *(Appendix 3 "Client Relations Form).*
- Inform the individual of the name and telephone number of the person investigating the complaint.
- Direct the complaint to appropriate person, manager/sector or level of organization.

COMPLAINT REVIEW

Manager/Director

Upon receipt of complaint, the person who will be carrying out the investigation will:

- Contact complainant within two (2) working days to acknowledge receipt of complaint.
- Identify him/herself as the one who will be looking into their concern.
- Review and confirm the details of the complaint.
- Discuss the investigation process including anticipated timelines.
- Discuss potential options to resolve complaint (it is important to find out what the complainant is expecting as a resolution).
- Inform the complainant of their right to have an advocate.
- Inform the complainant that the complaint will be investigated as objectively and thoroughly as possible and the results will be communicated in writing, if they so desire.
- Inform the complainant of appeal mechanisms, (involve Patient/Client Relations).
- Ensure complainant knows how to contact person managing the complaint.
- Provide information to the complainant as requested – the complaint may be resolved at this stage.

Decide on severity of complaint:

- For complex complaints involving multi-units/disciplines refer to Patient/Client Relations to take on the coordinating role and be the "point person" for the complainant.
- If litigation, a claim, human rights complaint or media exposure is likely or if the severity rating is considered high, refer to Risk Management and Patient/Client Relations for consultation and assistance immediately. After hours and on weekends, notify the Administrator on Call/Duty Administrator.

INVESTIGATION PROCESS

- Conduct investigation as quickly as possible. Research shows that the more quickly a complaint can be resolved, the more satisfied the customer and the more likely the customer would view the organization in a positive manner.
- Review all aspects of the issue, including context, using who, what, where, why, when and how questions when reviewing the facts (including what was attempted to resolve the complaint initially). Use a variety of sources when collecting facts – chart review, interviews with involved individuals and other staff not directly involved.
- Consult with Patient/Client Relations staff if advice/support wanted.
- Document all facts, including sources.
- Identify related issues, standards of practice, and policies.
- Evaluate collected data and information to determine possible grounds for the complaint.
    - Occasionally expert advice will be required to evaluate the case objectively.
- Inform complainant if timeframes differ from those discussed initially.
- Respond to the complainant with the findings of your investigation.
- If Patient/Client Relations or Risk Management is involved, copy them with your response.
- Document complaint investigation process and findings, and resolution if possible. Make recommendations to address the issues raised in the complaint and, if appropriate, to prevent reoccurrences.
- Involve primary staff member in process and discussion about plan.

CLOSING THE COMPLAINT

As soon as possible, after the investigation is completed, inform the complainant of the outcome of the review. The nature and severity of the complaint, as well as the wishes of the complainant will determine the final complaint review and whether a written report is necessary.

Communication with the complainant is:

- factual and objective;
- will state the complaint;
- will outline the review process and findings;
- will outline role of primary staff worker while client remains on service; and,
- indicate improvement activities the organization is taking to address the issues identified.

If the complainant is satisfied with the remedy(ies) or does not respond to the complaint report, the complaint can be closed.

If the complainant is not satisfied, then the process may be re-negotiated or it may be agreed that no resolution can be reached at this level.
If Patient/Client Relations has been involved and the complainant wishes to take the complaint further, inform them of the next steps, Ombudsman, Ministry of Health Services, College of Physicians and Surgeons, professional associations, etc.

Document outcome and forward copy of same to Patient/Client Relations staff, as appropriate.

6. TOOLS AND FORMS

See attached Appendices.

7. DEFINITIONS

For the purposes of this policy, a complaint is an expression of dissatisfaction that cannot be addressed with the usual patient/client and caregiver interaction.

8. REFERENCES

1) Ombudsman of BC, Public Report No. 40, Sept. 2001 – Developing an Internal Complaint Mechanism.
2) Complaint Management Guidelines for BC Health Authorities, HABC, 1998.

In original copy only

Issued by: **Signature of issuing official:** **Date:**

APPENDIX 1

PRINCIPLES RELATED TO COMPLAINT MANAGEMENT

Flexibility - to permit reasonable accommodation of the individual in the process.

- Feedback can be provided in a variety of ways that best suit the individual (e.g., in person, in writing, by fax, e-mail, telephone, etc.).

Accessible - to assist contact by the individual or someone acting on behalf of the individual.

- Information is readily available to the community about the process.
- Education is provided to staff about the process and they understand their role in the process.

Sensitive to Language and Culture -to seek to provide multilingual access to the processes and materials on rights, responsibilities, and how to complain and be sensitive to diverse cultural attitudes.

- Materials are provided in the main languages of service delivery.
- There are suitable alternative arrangements that can be made to assist the diverse population.

Consistent – to ensure the process is applied reliably across the range of services provided by the VCHA.

- Information is readily available to the staff about the process.
- Standards of service are in place, readily available so staff know what the expectations are, and are regularly monitored.

Accountable - to link feedback information to other quality improvement process and activities, to be answerable to the community.

- Information about complaints is regularly gathered, analysed and used to monitor and improve services.
- Client and staff satisfaction with the process is monitored.

Timely - to address issues raised in an expedient manner, with specific timelines set for each step.

- There are monitored time limits within each step of the process.

Respectful of Administrative Fairness and Natural Justice Ethics - to follow the values of due process, clear explanations, independent case consideration and the individual's right to be heard.

- Arrangements are in place to ensure full and fair review of all feedback.
- There is provision for independent review of all decisions that result from the feedback.
- Mediation and adjudication procedures are in place for anyone who is dissatisfied with the result.
- Confidentiality of individuals is respected.

Resolved at the Local Level - to provide opportunities for learning, teamwork and empowerment at the level where the issues first arise are important.

- Staff are provided training about the process, and in the other skills (e.g., interpersonal) as maybe needed.

APPENDIX 2

CATEGORIES OF COMPLAINTS

To support system improvement and benchmarking the following standardized categories of complaints will be used:

a) **Accessibility: delayed, denied, unavailable:** Any issue related to service accessibility including: waiting times, cancellation of procedures, tests or results, and admission to service.

b) **Attitude/Conduct:** The extent to which any member of the health care team is perceived and/or demonstrates behaviours inconsistent with courteousness, helpfulness and sensitivity to client/family members. Negative attitude includes discrimination, abuse, harsh manner, rudeness and lack of attention.

c) **Accommodations:** Issues related to assignment of accommodation, information on accommodation, inappropriate placement, etc., when VCHA is providing the accommodation.

d) **Care: deficiencies in care, misdiagnosis, medication issues, etc.:** The extent to which any member of the health care team demonstrates professional skills, e.g., perception of problems arising from the provision or omission of medications.

e) **Communication:** Refers to breakdown in communication, miscommunication, lack of information, lack of clarity in explanations, and willingness to answer questions.

f) **Coordination:** Extent to which coordinated and seamless care and services are provided.

g) **Discharge:** Refers to the degree to which client/family is prepared for discharge including planning, timing and discharge information and education.

h) **Environment:** Refers to the degree to which the room, department, facility, environment, and/or resources meet expectations in terms of cleanliness, comfort, upkeep, meals, parking, etc.

i) **Financial:** Any issue related to the completeness or accuracy of charges for which a client, patient or third party is billed including costs for preferred accommodation or related to the management of resident accounts in residential care settings.

j) **Administrative Fairness:** Any issue related to the discharge of responsibilities as dictated by rights, legislation, or policy and procedure. This includes issues related to the interpretation and application of external and internal directives; access to, content and/or disclosure of information (e.g., documentation and confidentiality).

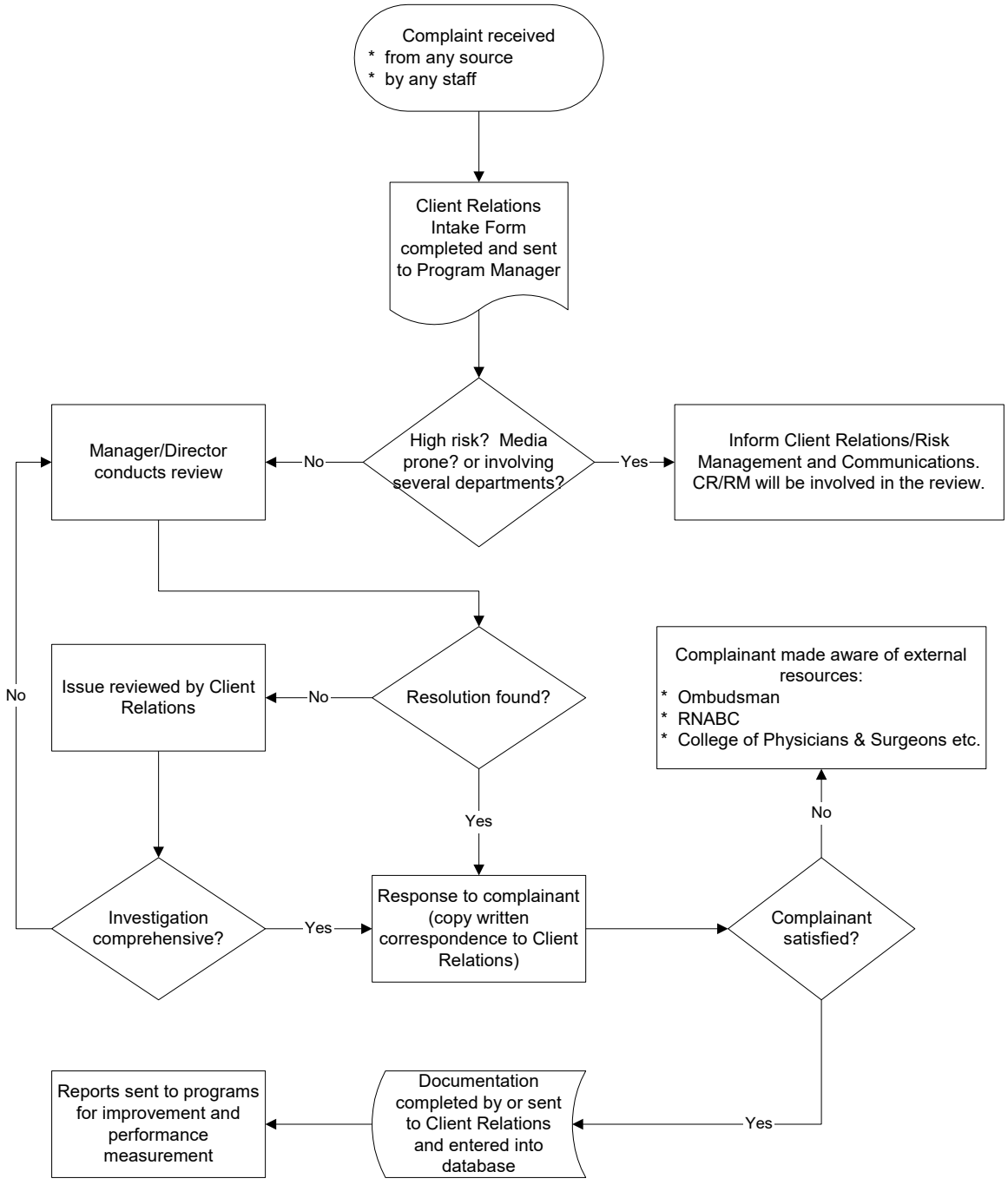
k) **Lost Articles:** concerns raised relating to lost or misplaced personal items during the patient/client's attendance in hospital/departments/clinics.

l) **Confidentiality:** issues which relate to FOIPPA ie: requesting access to personal health data; alleged breaches of confidentiality.

m) **Safety:** The extent to which provisions are made to ensure the safety and security of self and property including loss, theft, personal injury, or accident. Material (personal belongings and valuables) and personal (relates to the self).

n) **Equipment and Supplies:** Matters related to the availability/appropriateness of accessing specific medical equipment and supplies.

COMPLAINT MANAGEMENT PROCESS



Instructions (*see over for definitions)**:**

- send the form to the Patient/Client Relations office, along with any supporting documents
- do not file a copy on a client's health record, as this form is an administrative document
- complete as much 'identifying' information as possible

1	**Date of Call/Inquiry:**	**Received by:**
	Referred to (Manager name):	**Date Referred to Client Relations:**
2	**Patient/Client Surname:**	**Birthdate:**
	Patient/Client First name:	**Client Identifier # (CCD, MRN etc):**
	Address:	**PHN:**
		Date of Occurrence:
	Phone Number: ( )	**Date of Admission** (if appropriate)**:**
	Alternate Number: ( )	**Date of Discharge** (if appropriate)**:**
***3**	**HSDA**:	**Site:**
	Location:	**Program:**
***4**	**Caller's Surname:**	**Phone Number: ( ) -**
	Caller's First name:	**Alternate Number: : ( )**
	Address:	
	Complaint/Inquiry by: ❑ phone ❑ in person ❑ letter/fax ❑ email	**Relationship to Patient/Client:**

5 Intake	**BRIEF DESCRIPTION OF ISSUES OR CONCERNS IDENTIFIED:**
Points to Consider:	
What caller is dissatisfied with and why	
What action they wish taken	
What actions have occurred	
Support they need to proceed	

***6 Classification**: *choose one only*

❑ Inquiry ❑ Suggestion ❑ Compliment ❑ In-house request for support
❑ Complaint (Minor) ❑ Complaint (Intermediate) ❑ Complaint (Major)

***7 Category:** *choose all appropriate*

	Concern Warrants Action/QI		Unmeetable Expectations	
❑ Accessibility	❑ Yes	❑ No	❑ Yes	❑ No
❑ Accommodation	❑ Yes	❑ No	❑ Yes	❑ No
❑ Administrative Fairness	❑ Yes	❑ No	❑ Yes	❑ No
❑ Attitude	❑ Yes	❑ No	❑ Yes	❑ No
❑ Care	❑ Yes	❑ No	❑ Yes	❑ No
❑ Communication	❑ Yes	❑ No	❑ Yes	❑ No
❑ Challenging Patient/Family Behaviour	❑ Yes	❑ No	❑ Yes	❑ No
❑ Confidentiality	❑ Yes	❑ No	❑ Yes	❑ No
❑ Coordination	❑ Yes	❑ No	❑ Yes	❑ No
❑ Discharge	❑ Yes	❑ No	❑ Yes	❑ No
❑ Environment	❑ Yes	❑ No	❑ Yes	❑ No
❑ Financial	❑ Yes	❑ No	❑ Yes	❑ No
❑ Lost Articles	❑ Yes	❑ No	❑ Yes	❑ No
❑ Safety	❑ Yes	❑ No	❑ Yes	❑ No
❑ Supplies/Equipment	❑ Yes	❑ No	❑ Yes	❑ No

8 **Actions**: *choose all appropriate*

- ❑ No Further Action Required
- ❑ Access to Service Provided/Denied
- ❑ Apology Issued
- ❑ Arranged Communication Between Involved Parties
- ❑ Employee Received Education/Monitoring re: Attitude/ Conduct
- ❑ Referred To Appropriate Agency Within VCHA
- ❑ Dealt With As Actual Or Potential Claim
- ❑ Change to Service
- ❑ Change to Policy/Procedure
- ❑ Provided Information
- ❑ Reassessment of Client Care Level By Professional
- ❑ Employee Received Education/Monitoring re: Knowledge/ Process
- ❑ Referred To Appropriate Agency Outside VCHA
- ❑ Acknowledgement (letter or phone call)

9 **Status of Client/Patient Relations file**:

- ❑ Closed - or six months following last contact

10	**OUTCOME**
Actions	
Recommendations	
Outcome	
	❑ Client known to be satisfied ❑ Client known not to be satisfied ❑ Unknown

Guidelines for use of this form:

HSDA:	One of four Health Services Delivery Areas in VCHA – NSCG, Richmond, Van Acute, Van Community
Site:	A care facility within the particular HSDA (i.e. VGH for Van Acute, Ravensong for Van Community)
Location:	The unit, ward, clinic etc. where the issue occurred
Program:	The larger programmatic structure that the issue falls under (i.e. Seniors, Cardiology)
Caller:	The person who initiates contact with VCHA on behalf of the patient/client

<u>Classifications</u> (definitions from Radicalogic):

Inquiry — A question or request for clarification of information

Suggestion — A remark that is intended to provide information on how to change or improve care or service

Compliment — Any comment that commends the organisation or an individual associated with the organisation

Complaint (Minor) — Resolution is straightforward, consisting of an explanation, clarification of policy/procedure, or simply apology.

- Matter requires clarification of the law
- Issue is one-dimensional, i.e. nurse was rude, food not good, room dirty
- Response to issue is by way of follow-up from Manager (final response is either directly from Manager to complainant or CRRM drafts the response from the Manager's information and sends out to complainant).

Complaint (Intermediate) — Resolution requires investigation, meeting with family/client and other providers, minor changes to policy or procedure, minor discipline of staff.

- More in-depth response to issue is required, i.e. not straightforward as in minor classification
- Final response and follow-up is coordinated through CRRM due to two or more service areas involved in investigation and response.

Complaint (Major) — Resolution requires extensive investigation, meetings, major policy revisions or reporting of events to regulatory body or authorities. File must meet at least two criteria for the classification of major to apply.

- Time by CRRM spent on file (concept of time not calculated on the basis of weeks/months but actual hours spent coordinating, documenting, and so forth)
- Extensive investigation and meetings required with patient, family, staff, internal and external stakeholders)
- Major policy revision or procedural changes identified
- Reporting required to HCPP or regulatory body/authority
- Significant breach of legislation or alleged contravention of policy or law.

Procedure for Handling Small Claims
(Patient / Client Relations)
11 February 2003

"Small Claims": Any alleged loss or damage related to personal items, reported by patient, family or their representative that totals less than $1000. The handling of these claims will be managed in house, by the appropriate Health Service Delivery Area (HSDA) Patient/Client Relations representative. There is no requirement to report small claims to our insurer.

Reporting the Loss:
Once the loss has been reported by the patient/family, an Incident Report will be completed by the staff person receiving the report. (Note: If Patient/Client Relations is the first point of contact by the patient, the Manager responsible for the area will be contacted by Patient/Client Relations to begin the investigation and complete the Incident Report.)
The Manager/delegate for the unit or program area conducts the investigation and determines if any reimbursement is appropriate. Reimbursement to patients will be applied against the Manager's cost centre. In certain cases, the Manager may decide that replacement value reimbursement is appropriate, rather than depreciative value. The Manager will forward the Incident Report and supporting documentation to Patient/Client Relations, who will coordinate payment between the patient and Finance. If the Manager determines that no reimbursement is appropriate, Patient/Client Relations will advise the patient or family of this decision. Note: See "Advising the Claimant" for decision making criteria.

Loss/Damage to Items over $250, but less than $1000.
A "Final Release" must be signed by the patient/family before a cheque will be processed. Patient Relations will submit the Final Release, Incident Report and supporting documentation to Finance, with recommendation to reimburse the patient.

Loss/Damage over $1000
Any alleged claim for a loss over $1000 must be referred to our insurer. Patient/Client Relations acts as the liaison between the insurer/HSDA and the patient/family. The claimant must be prepared to provide evidence/documentation/receipts to support the alleged loss. The Incident Report and other documentation will be forwarded to the insurer. Any pay out is based on depreciative value, not replacement value. The claimant is required to sign a Final Release prior to any payment.

Hearing Aids/Dentures/Eye Glasses
As these items are necessary for a patient's quality of life and are generally expensive to replace, the following process will apply. All claims over $1000 will continue to be managed by our insurer. As our insurer provides pay out on depreciation only, Patient/Client Relations will negotiate with the Manager of the area to pay for the remaining costs for replacement, if the investigation determines that the HSDA is at fault.

Advising the Claimant
Patient/Client Relations will notify the patient/family of the outcome of the investigation.

Reimbursement may be based upon depreciative value, not replacement value. (50% of replacement cost). The patient/family should be made aware of this factor.

If the Manager finds that no reimbursement is appropriate, it may be helpful to share the investigative process with the claimant. In Vancouver Acute HSDA, for example, decisions are reached based upon the following criteria:

- Did the patient complete the “Personal Effects” release.
- Is there documentation within the patient’s health record detailing personal effects
- Does Transportation or Patient Escort have any record of taking personal items from one location to another
- Is there any documentation supporting personal items (money, jewelry, etc)going for safekeeping in the Cashier’s office
- Did the patient have the ability and cognition to be in care and control of these items.

Negotiating

At times, the patient may disagree with the decision of the Manager. Patient/Client Relations can attempt to negotiate with the claimant by reviewing what the Manager is willing to pay, looking at the total value of the loss, factoring in the depreciation and finding a figure somewhere in the middle. This should be discussed with the Manager first, however, as the costs are still extracted from the Manager’s cost centre.

Resource Material (Vancouver Acute)

The following materials are provided to patients. These resource materials clearly outlines that the hospital cannot be held responsible for lost or stolen items.

- Patient and Family Handbook (Van-Acute)
- “Preparing for Surgery – Pre-operative Information for Patients” (Pre-Admission Clinic)
- Personal Effects Release Form (Admitting)

FINAL RELEASE

THIS RELEASE is in respect of damages for PROPERTY DAMAGE/LOSS

IN CONSIDERATION of the payment of the sum of
_____ Dollars ($_____)

and which is directed by the undersigned to be paid as follows:
_____ Dollars ($_____)
_____ Dollars ($_____)
_____ Dollars ($_____)

THE UNDERSIGNED hereby for themselves, their heirs, executors, administrators, successors and assigns

i) release and forever discharge the _____ (herein referred to as the "Release") from any action, cause of action, or claim for damages specified above where the injury or, as the case may be, the damage, has been sustained as at the date hereof or may be sustained thereafter, as a result of

_____

on or about the _____ day of _____ , 20_____.

ii) agree to not make any claim or take proceedings against any person or corporation who might claim contribution or indemnity under provisions of any statute or otherwise;

iii) agree that the said payment does not constitute an admission of liability on the part of the Release; and

iv) declare that the terms of this settlement are fully understood, that the amount stated herein is the sole consideration of this release and that such amount is accepted voluntarily as a full and final settlement of the claim for damages specified above.

Signed at this _____ day of _____ , 20_____.

READ BEFORE SIGNING
In the presence of:

_____ _____
CLAIMANT SIGNATURE ***PRINT NAME (CLAIMANT)***

_____ _____
WITNESS SIGNATURE ***PRINT NAME (WITNESS)***

_____
Address

Respectful Workplace & Human Rights Policy

1. Introduction

"A respectful workplace - one in which people work-together collaboratively, efficiently and effectively to meet organizational goals - is a critical ingredient for VCH's success in delivering excellent care, services and health promotion. A respectful workplace is foundational for a healthy culture that nurtures staff's physical and psychological well-being, engagement and performance." ***(VCH Senior Executive Team)***

Scope

This policy applies to all persons associated with VCH, including employees (unionized staff, administrative, and management), medical staff members (physicians, division and department heads) midwives, dentists, nurse practitioners, residents, fellows and trainees, students, volunteers, contractors and other service providers engaged by VCH, as well as visitors, clients, patients, and families.

This policy applies to conduct in the workplace, which includes VCH premises, and work-related conferences, events or gatherings. It applies to in-person (individual or group) communications and electronic communications, such as email and social media.

2. Policy

2.1. Behavioral Expectations

All persons associated with VCH are accountable for their own behavior and must conduct themselves in a civil, respectful, cooperative and non-discriminatory manner in the workplace and at work-related gatherings. English shall be used during work unless patient/client/resident requires different language or staff member is on approved break.

Regardless of position, showing mutual respect is a core "People First" value and work expectation. Think before you speak and do not talk or behave in a way that might intimidate, embarrass, offend or otherwise bother someone.

VCH does not tolerate bullying, harassment or other inappropriate comment or conduct towards a person that reasonably causes humiliation, intimidation or embarrassment. Nor will VCH tolerate any reprisals for persons who report a concern or file a complaint.

A Human Resources Advisor will contact the employee or physician within 3 business days where:

- the employee or physician reports a concern/complaint to their Supervisor, Manager or Department Head regarding the behavior of other(s); or
- the employee or physician contacts the VCH No-Bully line requesting advice for coaching or wishing to file a complaint regarding the behavior of other(s).

The HR Advisor will update the parties every 10 business days until the complaint investigation is completed.

VCH reserves the right to investigate incident(s), with or without the person's consent, if there are concerns about serious harm.

2.2 Definition

Bullying & harassment is defined as inappropriate comment or conduct targeted towards or about a staff member which the person knew or reasonably ought to have known would cause the staff member to be humiliated or intimidated.

Inappropriate comment or conduct can occur in many different settings, including one to one; group communication, or through electronic means i.e. email, social media, (Facebook/Twitter/Instagram/Pinterest etc).

Inappropriate comment and conduct include:

- actions (e.g. touching, pushing), comments (e.g. jokes, name-calling), or displays (e.g. offensive posters, cartoons);
- workplace incivility which includes rude or discourteous comments that display a lack of regard for others;
- overloading a particular person an unreasonable share of unpleasant jobs; deliberately withholding information or support necessary for a person to be able to perform work;
- humiliating a person through criticism or insults especially in front of colleagues or patients; shouting or yelling at individuals;
- recording staff members or managers/supervisors without their knowledge (consent to record the individual must always be requested and, while requests to be recorded should be thoughtfully considered, refusals to be recorded must be respected);
- gossiping, back-stabbing behavior, cyber-bullying;
- ignoring or excluding a particular person; rolling eyes, glaring or other non-verbal behavior intended to intimidate; and discriminating or harassing behavior based on a protected ground per the Human Rights Code.

Management initiatives communicated respectfully **are not** considered bullying and harassment, such as:

- expressing a difference of opinion in a calm manner;
- assigning work duties, setting workloads and deadlines;
- work instruction, correction or supervision;
- work performance evaluation; imposition of discipline; and
- transfers, lay-offs and reorganizations.

2.2. Witnesses Responsibility: Take a Stand – Lend a Hand

We all have a part to play in creating a safe and healthy work environment. VCH expects anyone who witnesses inappropriate comment or conduct, to support their colleague(s), intervene where appropriate (e.g. speak up and say the other person's behavior is not acceptable) and report the incident to the Supervisor, Managers or Department Head who are

accountable to act upon any situation involving inappropriate comment or conduct in accordance with this policy.

2.3. Options to Reporting and Resolving Inappropriate Conduct and Comment

2.3.1 Having the Conversation

If someone (including your Supervisor, Manager, Division or Department Head) behaves in a way that you feel is offensive do not assume the problem will go away. Sometimes the person may not be aware their behavior is offensive, and many individuals will change their behavior once they are made aware of the problem.

If you are comfortable, have an informal conversation by approaching the other person(s), explain how the behavior impacts you and ask them to stop. Do this calmly in a private setting.

2.3.2 Reporting the Incident(s) to Your Manager or Department Head

If you are not comfortable having the conversation directly with the person(s), then please contact your Supervisor, Manager or Department Head or call VCH's No-bully telephone line below. If you report your concern/complaint to your Supervisor, Manager or Department Head, they will contact an HR Advisor and the Advisor will follow up with you within 3 business days.

2.3.3 Call VCH No-Bully (1-844-662-8559) Telephone Line

You can phone VCH's No Bully telephone line (1-844-662-8559) regarding any concerns about inappropriate conduct or comment. During the call an Employee Engagement Associate will provide you with the opportunity to confidentially debrief your experience and ask whether you wish to: access counselling through EFAP and/or have an HR Advisor contact you to review your options for coaching or filing a complaint.

Counselling

Confidential EFAP counselling and wellness services will be offered to assist you in dealing with the effects of bullying or other inappropriate behavior and if you are unsure about proceeding, help you to determine how you would like to resolve the conflict.

Coaching

If you choose, an HR Advisor will contact you within 3 business days to discuss options to resolve the conflict/behavior including coaching advice on how to have a difficult conversation with the other person(s) in order to maintain the working relationship,

Verbal Complaint

You will also be given the option for the HR Advisor to speak with your Manager or Department Head and arrange a meeting with the parties involved to resolve the behavior.

Written Complaint

If you wish to file a complaint, an HR Advisor will call you and summarize your concerns on a complaint form which they will send to you for confirmation and signature. You will be updated by an HR Advisor every 10 business days of the progress until the investigation of the complaint is completed.

2.4. Other Resolution and Appeal Process

If you are dissatisfied or otherwise disagree with the results of an investigation conducted pursuant to this policy, you are not precluded from advancing complaints through the applicable collective agreement, relevant professional bodies, WorkSafe BC, or the BC Human Rights Tribunal. In the event you file a complaint outside of this policy, VCH reserves the right to not proceed if you filed a second complaint under this policy.

Your union representative may participate at any point under this policy.

2.5. Consequences for Violating the Policy and Confidentiality

Any staff member (including physicians) found engaging in inappropriate comment or conduct (such as bullying or discrimination) or who retaliates against the complainant, will be subject to remedial and/or disciplinary action such as: a warning, direction to issue a written apology, a behavior agreement, transfer, counselling, demotion, dismissal, cancellation of contract and/or revocation of privileges pursuant to applicable Health Authority processes. Staff filing complaints in bad faith may be subject to disciplinary action.

No information will be disclosed by any person during an investigation or resolution of a complaint under this policy except as necessary to enable due process.

3. References

"Nurses treat each other, colleagues, students and other health care workers in a respectful manner recognizing the power differentials among those in formal leadership positions, staff and students. They work with others to resolve differences in a constructive way."

College of Registered Nurses of British Columbia

"Collaborate with other physicians and health professionals in the care of patients and the functioning and improvement of health services. Treat your colleagues with dignity and as persons worthy of respect."

Canadian Medical Association Code of Ethics

Other health professionals have guidelines for respectful and collaborative work behavior outlined by their colleges and professional associations. Links to colleges and associations are available on the Health Sciences Association website at www.hsabc.org

Related Policies

- Social Media, Websites and Online Communication
- Information Privacy & Confidentiality
- VCH Partners in Care

Issued by:

Name: _____ Title: _____ Date: _____

Signature of issuing official