Handbook for Contractors with Lived/Living Experience of Mental Health/Substance Use Challenges

Peer Support Worker Program, Peer Led Workshops Program, and Consumer Initiative Fund

Consumer Involvement and Initiatives
Vancouver Community Mental Health and Substance Use Services
Vancouver Coastal Health

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1.0 Purpose

This Handbook has been compiled to provide information and guidance for Contractors with Lived Experience (CLE) of mental health and/or substance use (Peer Contractors) who are working in Vancouver Mental Health and Substance Use Services (VMHSUS) at Vancouver Coastal Health (VCH). This includes Peer Support Workers (PSW), Peer Led Workshops (PLW) Facilitators, and Project Leaders as well as CLEs. The Handbook should be kept and used as a reference document.

2.0 Introduction

Peer Contractors who work for VMHSUS provide a number of services to clients and members of the general public. Some policies, procedures, and forms apply to all Peer Contractors and some are specific to individual programs.

Prior to taking up their duties, all new CLEs will receive an orientation which provides information about Vancouver Coastal Health (VCH) and VMHSUS policies, guidelines, and procedures, as well as any site-specific and role-specific information.

An Orientation Checklist is provided in the Forms section of this Handbook and should be used as a guide during the orientation process.

This Handbook lists several of the most important policies and guidelines, but your supervisor will ensure that you are aware of all VCH and VMHSUS policies and procedures that may be relevant to your contract.

2.1 A Note About Language and the People We Serve

Language is a powerful tool and can subtly influence how we perceive ourselves and others, which affects our relationships and the services we provide. Many different terms are used to refer to the people served by VMHSUS programs.

The mental healthcare system tends to use “client” over “patient”, since “patient” can suggest someone passively receiving treatment for illness or injury. Clinicians such as occupational therapists will typically use “client”. “Client” may not be appropriate for PLW Facilitators and Project Leaders who are providing services to members of the general community.

The Peer Support and Peer-Led worlds often use “peer”, as this term promotes mutuality and empathy. “Person receiving services” is also used as a neutral and non-stigmatizing term, but it emphasizes the power difference between the person receiving vs the person providing services. “Service user” is also used as a neutral term but may be vague or unclear.

“Person with lived/living experience (of mental health and/or substance use challenges)” is a term that emphasizes the unique value of such experiences, which provide personal insight into the recovery process. Some people might not be comfortable self-identifying as someone with such experiences, but it is a requirement of working as a Peer Contractor.

“Consumer”, “survivor”, and “ex-patient” (of psychiatric services) have also been used since the 1960s/1970s and have a powerful history of self-advocacy during the civil rights movement.

You should expect to come across all these terms in your work. There is no ‘right’ term for all situations. Choose your language thoughtfully.

3.0 Background

The move to employ individuals with lived experience of mental illness as Peer Contractors of Vancouver Coastal Health began in the early 1990s. In 1995 the Consumer Initiative Fund was initiated. The Consumer Initiative Fund program was designed to provide opportunities for individuals with lived experience of mental illness to compete for contracts to provide services to other individuals in the community who also have lived experience of mental illness. Following the development of the Consumer Initiative Fund program, the Peer Support Program began in 1997 to enable trained Peer Support Workers to offer support to achieve personal goals, learn new skills, and link with community resources. From there, additional Contractors with Lived Experience were hired into other positions in the mental health service.

It has long been recognized that individuals with similar experiences can offer unique opportunities for learning and recovery to others like themselves that those without those same experiences cannot offer. The utilization of individuals with lived experience as contractors is now part of all programs within VMHSUS, whether in acute, tertiary, or community services. The Consumer Initiative Fund, Peer Support Program, and the Peer Led Workshops Program are intended to provide youth, adults, and older adults who have serious and/or persistent mental health and/or substance use challenges with opportunities to participate in programs run by peers and to achieve personal goals, learn new skills, and link with community resources.

4.0 VCH Policies and Guidelines Applicable to All Peer Contractors

These policies are the most relevant to Peer Contractors working in VMHSUS. The associated guidelines are based on VCH policies. Other VCH policies may also be relevant to Peer Contractors working in VMHSUS.

All VCH policies may be accessed online at the Shared Health Organizations Portal (SHOP) http://shop.healthcarebc.ca/ and also in **Appendix A** at the end of this handbook.

4.1 Hand Hygiene Guideline

The purpose of this policy is to help protect patients/clients/residents, healthcare providers, and visitors from transmitting and/or acquiring infections. Hand hygiene is universally accepted as the single most important method for infection prevention and control. See **Appendix A** for the associated policy.

4.2 Information Privacy and Confidentiality Guideline

VCH has ethical and legal obligations to protect personal information about its clients and workers. VCH may also be obliged under contract or other circumstances to protect confidential information.

The purpose of this policy is to establish the guiding principles and framework by which VCH and its workers 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 and the public. See **Appendix A** for the associated policy.

4.3 Confidentiality Guideline

The VMHSUS recognizes the client's right of privacy in relation to their contact with the service. In addition, whilst a client does not have the property right to their health records, they have the right to protection of all information contained therein.

Peer Support Workers: Confidentiality is related to Continuity of Care (**6.5 Continuity of Care**) and these two Guidelines should be reviewed together.

All information related to a client must be treated as confidential; this information may be written, verbal or in another form.

Confidentiality extends to everything learned in the exercise of duties in perpetuity. All client and administrative information must be kept private and in confidence.

Any misuse of client information shall be considered a breach of confidentiality and shall be reported to the Contract Supervisor. Disciplinary action will be taken up to and including termination of placement or contract.

Please refer to the confidentiality undertaking document that accompanied your letter of agreement. See **Appendix A** for the associated policy.

4.4 Standards of Conduct Guideline

Peer Contractors are to be held to the same minimum standards of conduct as staff. See **Appendix A** for the associated policy.

4.5 Respectful Workplace & Human Rights Policy

"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) See **Appendix A** for the associated policy.

4.6 Client Complaint Management Policy and Guideline

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. See **Appendix A** for the associated policy.

5.0 Other Guidelines:

5.1 Guideline for Contractor Disagreements or Complaints

Whenever a Peer Contractor has a complaint, the complainant should first attempt to communicate and resolve the matter with the other party or parties involved.

If that does not resolve the situation, the Peer Contractor should speak to their Contract Supervisor who will work with the persons involved to resolve the problem.

Peer Support Workers: This can be escalated to the Peer Support Program Coordinator if the situation has not been resolved.

If this does not result in a resolution to the problem, the Contract Supervisor will follow the VCH complaint process and the complaint will be documented and resolved per VCH procedures.

5.2 Personal Relationships

Peer Contractors working in VMHSUS work in a position of trust with vulnerable people. Although supportive relationships can and should develop between Peer Contractors and those who are receiving services, forming friendships outside of this relationship is discouraged because of the inherent power imbalance between people receiving services and Peer Contractors providing services. Accordingly, contact between Peer Contractors and clients must be limited solely to professional relationships. Peer Contractors may not enter into a personal relationship with any client for at least one year after participation in the service has ended.

Sexual/romantic relationships between Peer Contractors and clients are unethical and are not allowed under any circumstances.

As with all mental health and substance use staff, Peer Contractors do not give out their personal contact information.

Peer Support Workers: If a client would like to contact a Peer Contractor, they can contact the team reception who will contact the Peer Contractor.

Peer Led Workshops Facilitators: If a client/workshop participant would like to contact a Peer Contractor, they can contact the Peer Led Workshops Coordinator who will contact the Peer Contractor as appropriate.

Peer Contractors who find themselves in the same social setting as a client/workshop participant or former client/workshop participant (e.g., at the same drop-in centre, or at the same social gathering) will respect confidentiality. Unless it is scheduled as part of the service, the Peer Contractor will be friendly but not discuss anything that has been part of the professional relationship (e.g., anything learned about the client's/workshop participant's personal life, or that the client/workshop participant is seeking/has sought services) with either the client/workshop participant or anyone else during the social gathering or at any other time outside the professional relationship. Peer Contractors who find themselves in the same social setting as a current client/workshop participant, will also share this situation with their Contract Supervisor.

Peer Contractors are responsible for ensuring that others with whom they work (e.g., project assistants) are aware of this information and for ensuring adherence to it, to the best of their ability. Any Peer Contractor who becomes aware of, or suspects that there may be, an instance of behaviour that violates this policy, is required to report this to their Contract Supervisor immediately.

Peer Contractors who have questions or concerns about this guideline or about how to behave toward a particular individual(s) are strongly encouraged to discuss this with their Contract Supervisor.

6.0 Information for All Peer Contractors

6.1 Before Work Starts

Before a Peer Contractor begins work with or around clients/workshop participants the following must be completed:

6.1.1 Contract Process

All Peer Contractors will be required to sign and return a contract before beginning work. The Peer Support Services Agreement FAQ (**Appendix B**) should be read to accompany the signing of a contract with a new contractor.

The VCH Privacy and Confidentiality course should be completed online through LearningHub at the beginning of a new contract and every two years thereafter. Instructions to complete the course are found in **Appendix B**. The VCH Information Privacy & Confidentiality policy can be found in **Appendix A**.

6.1.2 Completion of All Required Forms

The forms to be completed are the Confidentiality Statement, Respectful Workplace Statement, and Emergency Contact form (Appendix C). Copies of all three are to be kept at the work site and also sent to Consumer Involvement and Initiatives at Central Office.

6.1.3 Orientation

All Peer Contractors are to receive a thorough orientation from their supervisor that covers:

a) the contents of this Handbook that apply to the Peer Contractor's situation,
b) the topics included on the Orientation Checklist provided in **Appendix A**, and
c) any other information needed for the Peer Contractor to provide their services.

6.1.4 Criminal Record Check

Any Peer Contractor working with clients/workshop participants must satisfactorily complete a Criminal Record Check through the BC Ministry of Justice.

a) See **Appendix B** for the Frequently Asked Questions about: Criminal Records Checks

6.1.4.1 Criminal Record Check Requirements

VCH must receive a completed Criminal Record Check (CRC) from all applicants for contract positions that fall within the purview of this Handbook, including applicants for the Peer Support Worker Training Program. Legislation also requires that all CRC's be repeated every five years.

The CRC application (done through the Ministry of Justice) must be completed and returned to the Coordinator, Consumer Involvement and Initiatives, **before** the contractor begins work.

The Consumer Involvement and Initiatives program will cover the cost for Peer Contractor CRC applications and will submit the appropriate forms to the Ministry of Justice.

Please respond to any request from the Ministry of Justice related to your application. If you require support from VCH, please contact your Contract Supervisor.

It is not unusual to be asked to have fingerprints done, and if you are requested to do so, that cost is to be covered by the site where you will work.

Decisions regarding criminal records clearance are made solely by the Ministry of Justice. Peer Contractors are able to work with VCH once their application has been submitted and until proven otherwise by the Ministry of Justice.

For more information about the Ministry of Justice CRC process, go to
https://www2.gov.bc.ca/gov/content/safety/crime-prevention/criminal-record-check

6.2 During Your Contract

6.2.1 Absence from Work

If a Peer Contractor becomes unable to fulfill their contract requirements, they must notify the Contract Supervisor immediately and inform the Contract Supervisor about any client appointments, sessions, workshops, or groups that have been scheduled as well as their expected return date. If needed, the Contract Supervisor will find a suitable substitute Peer Contractor to fill in for the original Peer Contractor. In this case, the substitute Peer Contractor will be paid for the service provided and the original Peer Contractor will not bill for the missed service.

Peer Support Workers: If it is to be a lengthy leave and the involved staff feel that it is of importance that the program be able to provide peer support during that time, negotiations for a substitute or replacement posting will take place between the involved staff, the Peer Support Worker and the Peer Support Coordinator. If the Peer Support Worker expects to be able to return to work within a short period of time and is concerned about losing pay, Discretionary Payments can be offered. See **6.3.1** for guidelines on Discretionary Payments.

6.2.2 Entering a Client's Residence

A Peer Contractor is restricted from entering a client's residence unless they are working for the Mental Health Supported Housing team or VGH Segal or there are special circumstances such as working with an older adult who is not physically mobile. In every case, the Peer Contractor must have permission from the Contract Supervisor before entering a client's residence and follow VCH policy and procedures to ensure safety.

6.2.3 Incident Reporting and Liability – Safety Learning System (SLS)

If a Peer Contractor is with a client when an incident occurs and there is harm to the client and/or to the Peer Contractor, the incident must be reported as soon as possible.

For clients, a “near miss” (situation where harm was averted) should also be documented.

Harm to client:
When a client has been harmed, the staff member most responsible for the client is to be informed and the staff member must report the event in the Safety Learning System (see example in **Appendix D**). Near miss incidents should also be documented.

Harm to Peer Contractor:
Peer Contractors are covered under WorkSafeBC under the VCH account while they are working on an active contract. If the Peer Contractor has been injured while at work the Contract Supervisor is to be informed. The Contract Supervisor must report the incident to their work site Manager and the Manager of Consumer Involvement and Initiatives, or their delegate. he Peer Contractor will call in to WorkSafeBC at 1 (888) 621-7233 to report the injury and identify as a Peer Contractor with VCH. The Employer must also fill in associated paperwork for WorkSafeBC. Supervisors -please see the expanded guidelines for more info on how to report.

6.3 Related to Payments

6.3.1 T4A and Taxes

Peer Contractors will receive T4A statements for income tax purposes if they receive over $500 in a calendar year from VCH. No deductions are taken off payments to Peer Contractors. Depending on your earnings for the calendar year, you may be asked to pay CPP and income tax.

6.4 Contract Review

For Peer Contractors who are covered by this Handbook, the following will apply:

- During a Peer Contractor’s first contract with a new site, with a new program, or when a new contract with different deliverables has been executed, a contract review will be done at three months.
- A contract review may be carried out sooner at the discretion of the Contract Supervisor.
- A contract review will be conducted with each contract renewal.
- Contract reviews may also be done as needed, determined by the Contract Supervisor.
- If any concerns are identified during the contract review, the Peer Contractor will have an opportunity to improve performance to meet contract deliverables prior to the end of the contract.

See **Appendix C** for the Contract Review Form.

7.0 Information Specific to Peer Support Workers

Peer Support Workers offer practical, social, and emotional support to clients who are learning how to manage their recovery journeys. They can work with community mental health/substance use teams, specialized units, and hospital units. They utilize their lived/living experience of mental health and/or substance use recovery in addition to specialized training in supporting others. This typically takes the form of supporting clients in achieving goals, learning new skills, and connecting with community resources.

7.1 Peer Support Worker Roles and Responsibilities

- Provide practical, social, and emotional support to clients of VMHSUS,
- Meet one-to-one with assigned clients, generally away from VMHSUS program sites,
- Support clients to achieve specific client-centred and client-directed psychosocial rehabilitation goals,
- Complete and submit the required paperwork for each client contact, and
    - Goals/Outcomes form
    - Activity Log
- Complete and submit the required payment paperwork on a monthly basis

7.2 Documentation

Documentation is an important part of Peer Support Work within VCH. Proper documentation promotes continuity of care and communication between involved workers, demonstration of outcomes, protection from liability, reporting to funders, and compliance with legislative and VCH policies.

Documentation should be correct, concise, written clearly, and objective.

Documentation should also maintain Peer Support Worker values (Peer Support Canada, 2019):

- Hope and recovery: write from a strength-based perspective.
- Equal relationships: ask the client what they want included in documentation. Collaborate with the client and use the client's words whenever possible.
- Self-determination: documentation reflects that the client directs decision-making. The Peer Support Worker can ask, "What would you like to get out of today's meeting?" at beginning and at the end, "Did you get what you wanted out of today? Is there anything you would like to focus on next time?"

All Peer Support Work documentation will be available to all involved staff and should be stored in client files.

Documentation must also maintain confidentiality: identify clients by **initials only**.

7.2.1 Goals and Outcomes Form

Process: Overall

- This is completed in consultation with the client, Peer Support Worker, and Contract Supervisor, or other involved staff.
- The site will determine where Peer Support Worker documentation is stored.

Process: Page 1

- The first page is written when the client, Peer Support Worker and potentially involved staff meet with a goal(s) and plan(s).
- Goal creation should come from the client and empower the client.
- Goals can be simple/broad/vague. Plans should be SMART.
- The PSW ensures Page 1 of the G/O form is stored at the site.
- The PSW also keeps a copy for their own peer support files for easy access.

Process: Page 2

- When an outcome has been reached for the goal(s), the form is completed by filling out the second page with outcome(s) and optional recommendation(s).
    - Potential outcomes include goal is reached, client changes goal, or goal is no longer being pursued
- The completed peer support form is kept in the client's hybrid chart.
- The PSW informs the supervisor that the G/O form is complete.
- A copy of the completed form is also sent to the Peer Support office
- Any other remaining duplicate copies are destroyed.

7.2.2 Activity Log

After each visit with their client, a Peer Support Worker documents the visit in the Activity Log.

Process:

- Completed activity logs are handed in to the Contract Supervisor and checked.
- The Peer Support Worker keeps a copy in their peer support files to assist their work until the associated client goal has been completed.
- Copies are destroyed once the associated client goal has reached an outcome.
- The site determines where Peer Support Worker documentation is recorded.
    - It is recommended that Activity Logs are stored in the client's hybrid chart and entered into electronic documentation by proxy, either by clinicians or by administrative staff.

See **Appendix D** for copies of these and others forms specific to Peer Support Workers.

7.3 Expenses

Depending on the nature of their work, Peer Support Workers can receive a small monthly stipend as stated in their contract to facilitate achieving clients' goals. This expense money is spent as determined by the client's goal and plan, and is not an entitlement.

The Peer Contractor will submit original itemized receipts for authorized purchases.

The amount of the stipend will be set out by the program and will be based on the goals of the clients of the Peer Support Worker. The expenses stipend is to be shared between all applicable clients of a Peer Contractor.

While travel to and from work is not compensated, travel between and with clients can come from the Expenses stipend at the discretion of the Contract Supervisor.

7.4 Location of Services Received vs. Provided

In general, Peer Contractors do not provide services at a team, unit or program where they currently receive services or where they have received services within the past year. Exceptions to this rule may be considered at the site's discretion.

7.5 Group Work

The PSW role may include group facilitation or co-facilitation. These groups should use a PSW's lived experience to support clients in achieving their goals.

A PSW might attend a group with a client to assist them in meeting their goals.

7.6 Continuity of Care

It is very important that PSWs, like other health professionals, know when and what to tell other involved staff about clients in their care. This sharing of information is called Continuity of Care. Continuity of care is closely related to confidentiality (**3.4**).

When a client discloses critical information (that the client is at risk of harm to themselves or others), involved staff MUST be advised as soon as possible. Some examples include, but are not limited to:

- A client discloses that they have or will stop taking their medications
- A client discloses problematic substance use or concerns about their substance use
- A client discloses that they plan to hurt themselves or another person
- A client discloses that they think life is not worth living/passive suicidality

- A client discloses they are going to or have changed address or other housing concerns
- A client discloses that someone else – another staff or PSW - is treating them badly
- A client discloses that they are leaving the province for a period to time

The critical information may relate to anything in the client's life.

Involved staff may include:

- The client's Case Manager or rehabilitation staff
- The Case Manager's alternate or other involved staff
- The PSW's Supervisor, or in that person's absence, other mental health staff
- Residential care staff
- The Peer Support Worker Program Coordinator, or
- The Clinical Supervisor of the team.

PSWs **cannot** share non-critical information with people outside the mental health/substance use program staff, unless told to do so by an involved staff person.

This is what confidentiality means.

PSWs **must** share critical information they receive from or about their clients with other involved staff – or, in their absence, any clinical staff – within the mental health/substance use service.

This is what of continuity of care means.

These two standards of care should be explained to the client at the beginning of a client-PSW relationship as one of the boundaries of such a relationship. The PSW should also inform the client when confidential information will have to be shared with involved staff because of continuity of care.

If a client is hesitant to share something with the PSW, the PSW should ensure that the client understands that the PSW is bound by these two standards. Then the client can make an informed decision about whether or not and how much they would like to share with the PSW.

If there is uncertainty about whether certain information should be shared, the PSW should consult (in a confidential manner) with involved staff.

7.7 Duty to Warn

This is a legal term referring to a provision in the law that allows service providers to break confidentiality when, using their best judgement, it is necessary to keep people safe. In addition to the situations described under Continuity of Care, if a Peer Support Worker suspects child abuse or abuse of a vulnerable adult (such as an elderly or disabled person), this must be reported in consultation with the contract supervisor.

It is crucial that a Peer Support Worker understands these standards and explains them to clients at the beginning of a client-PSW relationship. This explanation sets up healthy boundaries and establishes trust. It also provides something to call back to if the client makes a request that would break these or other boundaries.

7.8 Formal Back-up for Peer Support Workers After Hours – Evenings and Weekends

Most Peer Support Work is done within regular work site hours. In some cases, Peer Support Workers may work on weekends and evenings. After hours work must be approved by the Contract Supervisor on a case-by-case basis, provided that:

- The Peer Support Worker, Contract Supervisor and client are in agreement that the after-hours work constitutes part of the client's goal and cannot be accomplished during regular work site office hours.
- The client is well enough to be seen outside of office hours.
- There is general support organized by the Contract Supervisor for the Peer Support Worker from among the client's resources, for example, community, home, site staff, and family members.
- When a Peer Support Worker is meeting with a client outside of work site/office hours, the Community Manager on Call will be notified in case of emergency. The phone number is 604-809-0932. There is also an email option for non-urgent issues vcmoc@vch.ca.
- For instances where the client feels that they need immediate support, (similar to what they might access with their care team), the client is encouraged to go to the Access and Assessment Centre (AAC) at VGH.

  Access and Assessment Centre –
  803 West 12th Avenue, Level 1 East Entrance
  Call (604) 675-3700 or walk in between 7:30 a.m. – 9:30 p.m.

- In the event of an emergency, the Peer Support Worker will call 911.

7.9 Contract Guidelines

The Contract Supervisor will determine the terms of the Peer Support Worker contract. The contract is written up with a maximum value for the term. Many contracts are for a six or twelve month period for 20 hours per month. The Supervisor and PSW are jointly responsible for maintaining an active contract for the PSW. The Peer Support Coordinator will also check for expired contracts on a monthly basis and notify the Supervisor if any are found.

7.10 Allocation of Hours and Compensation

The Contract Supervisor takes responsibility for keeping the Peer Support Worker active and has the final say on how many hours of a contract go to a specific client. The Peer Support Worker records hours worked, payment sheets, and expense forms to submit to the Contract Supervisor for processing.

Work hours also include site orientation time and required training at the beginning of the Peer Support Worker contract, monthly meetings with the Contract Supervisor, and the monthly Peer Education Meetings organized by the Peer Support Program.

7.11 Client Short Notice Cancellation and Billing

If a client cancels with less than 24 hours' notice the peer support worker will note the cancellation and bill for two hours if the appointment was in-person and 30 minutes if the appointment was virtual (phone or video call).

In cases where a client cancels and is able to give 24 hours' notice of the cancellation, the Peer Support Worker does not bill for hours.

Appointment confirmations should be done more than 24 hours in advance of visits.

7.12 Minimum Payments

Peer Support Workers are to be paid for a minimum of two hours for a scheduled in-person client meeting, or if asked to travel to work for the purpose of attending a meeting. This is to account for travel time and expenses.

Brief pre-screening calls prior to in-person client meetings are considered part of the two hour appointment block.

For virtual client meetings, it is suggested that the sites pay a minimum of 30 minutes per appointment call with the peer billing in half hour increments. E.g., 10 min call is 0.5 hours billed; 40 min phone call is 1 hour billed etc. If the call is more than a check in, please factor in prep time for the virtual appointment.

If a contractor is doing appointment reminders, please schedule reminder calls adjacent to other work if/when possible.

7.13 Payment for Educational Opportunities

Peer Support Workers may bill for attending the monthly Peer Educational Meetings organized by the Peer Support Program.

Workshops or other educational activities held in lieu of the monthly Peer Education Meeting are also billable. The Peer Support Coordinator will indicate which of these activities are billable in advance.

Peer Support Workers may be informed about additional workshops and conferences that can be attended on a voluntary unpaid basis.

7.14 Education at Supervisor's Request

If a Contract Supervisor sees a need for a Peer Support Worker to receive education in a particular area and specifically requests that the Peer Support Worker obtain this education, the Peer Support Worker will be paid for the time spent receiving the education.

7.15 Education at Organization's Request

A Peer Contractor will be paid for any required training identified by VCH.

7.16 Peer Support Payments and Provincial Income Assistance/Disability Benefits

In May 2005, the provincial income assistance and disability legislation was amended by introducing a new section regarding the payments made to mental health consumers by a health authority or designated agency. This change was a direct result of a successful appeal in a case of a client whose disability benefit had been denied due to peer support payments received from a mental health agency.

Under the Schedule B Section 1 of the EA Regulation and EA for PWD Regulation, those payments are listed as one of the income exemptions. This section states that "payments made by a health authority or a contractor of a health authority to a recipient, who is a *"person with a mental disorder" as defined in section 1 of the Mental Health Act, for the purpose of supporting the recipient in participating in a volunteer program or in a mental health or addictions rehabilitation program is exempt from the net income calculation for the purposes of determining eligibility for an amount of income/disability benefits assistance*".

As with many other parts of legislation, the Ministry of Health policy provides additional information regarding those payments. According to this policy the types of cases listed below are not considered income for provincial disability benefits purposes and are fully exempt from provincial disability benefit earnings caps. Note: this is not related to income tax.
For example, at the time of writing (October 2022), a person on provincial disability benefits can earn up to $15,000 per year before income reduces their monthly provincial disability cheque. If the contract is eligible for the earnings exemption, they can earn an unlimited amount and not have it reduce their disability benefits cheque. As per the list below, Peer Support contracts are eligible for this exemption.

The Ministry identifies the following as eligible:

1) payments to participate in Therapeutic Volunteer Programs,

2) payments for the costs of fees for participating in recreation and leisure activities,

3) payments to cover the cost of participation as a presenter or participant in training and education seminars and conferences, public lectures on mental health/addictions treatment and management, and other related topics,

4) payments for formal or informal peer support, in accordance with the Ministry of Health Peer Support Manual (see Peer Support Coordinator for information),

Or

5) payments to cover the cost of travel, meals and honoraria for clients who are invited to participate in discussions with health authorities, or who present information regarding the planning, delivery or evaluation of mental health and addictions services.

Additional information can be found in the Ministry of Health Peer Support Manual (2001). The full Manual can be accessed on line at the Ministry website at: http://www.health.gov.bc.ca/library/publications/year/2001/MHA_Peer_Support_Manual.pdf.

7.17 Discretionary Payments

Discretionary funding may be accessed by the Peer Support Worker to compensate for lost earnings due to unexpected absences from work such as illness, injury, or bereavement.

If a Peer Support Worker becomes unable to fulfill contract requirements, they must notify their Contract Supervisor immediately and inform them about any client appointments, sessions or programs that have been scheduled, and their expected return date.

At the discretion of the Contract Supervisor, discretionary pay may be provided. Discretionary pay for the entire contract is calculated at $1/12^{th}$ of the maximum contracted hours at the same pay rate.

For example:
for a 6 month contract of 20 hours per month with an hourly rate of $17

(6 x 20) / 12 = 10 hours
10 x $17 per hour = $170

In this example the Peer Support Worker could access up to $170 (equivalent to 10 hours) of discretionary funding for this six month contract.

Regular contract payments that would overlap with the time determined to be discretionary, will not be made.

8.0 Information Specific to Peer Support Worker Contract Supervisors

The Handbook for Supervisors of Peer Support Workers is under development and will be a separate document.

Any staff member with supervisory tasks in their job description can be a Contract Supervisor. The Contract Supervisor provides direct placement support to the Peer Support Worker and negotiates the Peer Support Worker's contract.

Contract Supervisor tasks:

- plan the Peer Support Worker caseload
- fill in contract request form and send to CI&I Program Assistant and Peer Support Program Coordinator
- arrange to sign each contract, emergency contact form, and payment forms with a Peer Support Worker
- provide program orientation, including an orientation to safety guidelines
- document all peer support contacts with clients, including group attendance if a PSW is facilitating, in Paris as **CLIENT CONTACT-PEER SUPP WKR**.
    - ideally, this will include transcribed PSW Activity Log notes. At minimum there must be documentation that a visit took place
    - this responsibility can be covered by administrative staff
- provide support, supervision, and feedback as necessary to PSWs
- conduct a contract review at 3 months into a new contract, with each contract renewal, and as necessary to address any issues
- provide a place for PSWs to do and store paperwork, and
- host a monthly supervision meeting for all Peer Support Workers at their program.

These monthly meetings may also involve other staff and will:

- provide support,
- allow an opportunity for supervision and consultation, and
- assist with debriefing any situations that might arise.

Peer Support Workers, Contract Supervisors, Case Managers, and other staff may also meet individually as necessary regarding specific placement with clients.

8.1 Involved Staff's Responsibilities (staff whose client seeks a Peer Support Worker)

Involved staff will:

- discuss with the client the possibility of meeting with a Peer Support Worker
- support the client to set client-centred and client-directed goals
- introduce the client to the Peer Support Worker

- ensure that the supportive relationship, goal setting, progress, and completion process is effective
- provide all relevant client information verbally/in writing to the PSW
- assist the client and the Peer Support Worker as needed
- attend the monthly program meeting between the Peer Support Workers and their Contract Supervisor as needed.

9.0 Information Specific to the Peer Led Workshops Program

The Peer Led Workshops Programs offers a variety of workshops and support groups that are co-created by Peers.

Co-creation is a cooperative working style where Peers, professionals and content experts work together as equals to create a service that will improve the quality of life for members of the community. Co-creation holds the belief that those who use a service are in the best position to help design it.

Peer Led Workshops focus on empowering people to be active participants in their recovery and well-being. A Peer Led Workshops (PLW) Facilitator uses different skills, tools, exercises, and natural abilities to draw out knowledge and insight from workshop/group participants and keep discussions running smoothly. All Peer Led Workshops are co-facilitated by two PLW Facilitators.

The Peer Led Workshops Program is divided into two teams:

- FAN (Facilitator Access Network)
- Voices & Visions

Peer Led Workshops Facilitators may hold separate contracts with both teams.

9.1 FAN

FAN Facilitators co-facilitate Peer Led Workshops that include but are not limited to:

- Coping with Uncertainty (CWU)
- Plan for Wellness & Recovery (PWR)
- Talking With Your Doctor (TWYD)
- Your Recovery Journey (YRJ)

The list of Peer Led Workshops may change at the discretion of the PLW Contract Supervisor.

9.1.1 FAN Facilitator Roles and Responsibilities

- Co-facilitate virtual and in-person Peer Led Workshops
- Use workshop-specific materials to facilitate discussions and lead group activities
- Encourage participants to develop and use creative and critical thinking
- Work collaboratively with other Peer Facilitators
- Create and maintain a safe(r) and respectful group environment guided by how participants define safety and respect
- Set-up and take-down of room (may involve moving tables and chairs)
- Ensure everyone has a chance to express their ideas and feelings

- Share personal experience appropriately for the benefit of the participants
- Be open to a range of ways of understanding experiences
- Attend monthly team meetings
- Respond to the PLW Contract Supervisor by the determined deadline to express interest in the workshop(s) and role(s) they would like to facilitate (done quarterly)
- Confirm assigned role(s) each quarter
- Schedule and attend Planning Meetings with workshop-specific team(s)
- Communicate with site staff when applicable
- Promote the Peer Led Workshops programming
- Complete and submit the required payment paperwork on a monthly basis

9.1.2 FAN Team Meetings

FAN Facilitators may bill for attending the monthly team meetings organized by the PLW Contract Supervisor.

9.1.3 FAN Schedule

The FAN Schedule is created by the PLW Contract Supervisor for the following quarterly intervals:

- March/April/May
- June/July/August
- September/October/November
- December/January/February

Each quarter, the PLW Contract Supervisor creates a FAN Facilitator Opportunities document and sends it to the FAN team. This document includes the date(s), time, location, and other relevant information about that quarter's programming.

FAN Facilitators are responsible for replying to the PLW Contract Supervisor by the determined deadline to express interest in the workshop(s) and role(s) they would like to facilitate.

The PLW Contract Supervisor then assigns the FAN Facilitator roles for that quarter's programming and notifies the FAN team.

FAN Facilitators must then confirm their assigned roles.

Once all roles have been confirmed, the PLW Contract Supervisor sends the confirmed FAN Schedule to the FAN team.

FAN facilitators are then responsible for scheduling and attending Planning Meetings with their workshop-specific team(s). Planning Meetings take place via Zoom.

9.1.4 FAN Facilitator Supporting Documents

See **Appendix E** for FAN Facilitator Supporting Documents including, but not limited to:

- Hours and Payment Form –FAN Facilitators
- FAN Zoombombing Procedure
- FAN Backup Facilitator Procedure
- FAN Workshop Attendance Procedure

9.2 Voices & Visions

The Voices & Visions support groups are peer-led support groups based on the International Hearing Voices Network. Their aim is to be a place where people who hear voices, see visions, or have other unique sensory experiences can give and receive support, share techniques for living well with their experiences and/or explore the meaning those experiences have for them. The groups are facilitated by peers who support the smooth functioning of the group and make relevant resources available to participants.

9.2.1 Voices & Visions Facilitator Roles and Responsibilities

- Co-facilitate virtual and in-person support group meetings
- Work collaboratively with other Voices & Visions Facilitators
- Create and maintain a safe(r) and respectful group environment guided by how participants define safety and respect
- Set-up and take-down of room (may involve moving tables and chairs)
- Be open to a range of ways of understanding experiences
- Ensure everyone has a chance to express their ideas and feelings
- Draw on Hearing Voices Network resource materials in discussions and make these and other resources available to participants
- Share personal experience appropriately for the benefit of the group or individuals
- Attend quarterly team meetings
- Respond to the PLW Contract Supervisor by the determined deadline to express interest in the workshop(s) and role(s) they would like to facilitate (done quarterly)
- Confirm assigned role(s) each quarter
- Communicate with site staff when applicable
- Promote the Peer Led Workshops programming
- Complete and submit the required payment paperwork on a monthly basis

9.2.2 Voices & Visions Team Meetings

Voices & Visions Facilitators may bill for attending the quarterly team meetings organized by the PLW Contract Supervisor.

9.2.3 Voices & Visions Schedule

The Voices & Visions (VV) Schedule is created by the PLW Contract Supervisor for the following quarterly intervals:

- March/April/May
- June/July/August
- September/October/November
- December/January/February

Each quarter, the PLW Contract Supervisor creates a VV Facilitator Opportunities document and sends it to the VV team. This document includes the date(s), time, location, and other relevant information about that quarter's programming.

VV Facilitators are responsible for replying to the PLW Contract Supervisor by the determined deadline to express interest in the workshop(s) and role(s) they would like to facilitate.

The PLW Contract Supervisor then assigns the VV Facilitator roles for that quarter's programming and notifies the VV team.

VV Facilitators must then confirm their assigned roles.

Once all roles have been confirmed, the PLW Contract Supervisor sends the confirmed VV Schedule to the VV team.

9.2.4 Voices & Visions Facilitator Supporting Documents

See **Appendix E** for Voices & Visions Facilitator Supporting Documents including, but not limited to:

- Hours and Payment Form – VV Facilitators
- Voices & Visions Zoombombing Procedure
- Voices & Visions Support Group Attendance Procedure
- Voices & Visions Support Group Checklist

9.3 Contract Guidelines

The Contract Supervisor will determine the terms of the PLW Facilitator contract. The contract is written up with a maximum value for the term. Many contracts are for a six or twelve month period with a maximum of 20 hours per month. The Contract Supervisor is responsible for maintaining an active contract for the PLW Facilitator.

9.4 Payment for Educational Opportunities

PLW Facilitators may be informed about additional workshops and conferences that can be attended on a voluntary unpaid basis.

9.5 Education at Supervisor's Request

If the PLW Contract Supervisor sees a need for a PLW Facilitator to receive education in a particular area and specifically requests that the PLW Facilitator obtain this education, the PLW Facilitator will be paid for the time spent receiving the education.

9.6 Education at Organization's Request

A Peer Contractor will be paid for any required training identified by VCH.

9.7 Facilitating on Zoom

PLW Facilitators need to be comfortable facilitating on Zoom. See **Appendix E** for a brief step-by-step guide. Further support with Zoom is available to PLW Facilitators and may include training.

9.7.1 Zoombombing

Zoombombing is the unwanted, disruptive intrusion into a video-conference call.

In the event of a Zoombombing incident, please refer to Zoombombing Protocols in **Appendix E**.

10.0 Information Specific to the Consumer Initiative Fund Program

The Consumer Initiative Fund (CIF) is a program that funds and supports projects that are proposed, managed, and led by people with lived experience with mental health and/or substance use.

CIF also funds a Crisis Grant (intended to assist mental health and substance use consumers who are experiencing significant financial strain due to unexpected circumstances) and an Education and Leisure Fund (intended to provide opportunities for individuals to take courses they would not otherwise have access to and to build capacity).

10.1 Project Leader Responsibilities

- Oversee all aspects of the project, ensuring that it runs smoothly and fulfills its mandate and deliverables.
- Monitor the project budget to ensure that spending is on target.
- In accordance with contract deliverables: make payments for services and supplies as needed and complete all necessary reimbursement requests and financial reports.
- Complete and submit all other reports as required.
- Organize and oversee all activities/events/courses/bursaries of the project.
- Attend all required Consumer Initiative Fund meetings/workshops.
- Maintain regular contact with the Program Coordinator to keep them informed of progress and problems.
- Adhere to VCH policies and procedures.
- Together with the Program Coordinator, make decisions regarding problems that arise, following established procedures and protocols.

10.2 Reporting

- The Project Leader reports to the Consumer Initiative Fund Program Coordinator.

10.3 Protocol for Cancelling Sessions of a Consumer Initiative Fund Project

If the Project Leader or Assistant Project Leader of a Consumer Initiative Fund Project becomes ill or unable to provide the service agreed to in the Letter of Agreement with Consumer Initiative Fund, the Project Leader or Assistant will:

- Inform the Consumer Initiative Fund Program Coordinator.

If the Project Leader or Assistant is unable to continue the project alone, or if there is only a Project Leader and that person is unable to continue, the following procedure will be followed:

- Once the Consumer Initiative Fund Program Coordinator becomes aware that there are problems or potential problems in a Consumer Initiative Fund project, the Program Coordinator will:

- Speak with the individual who has brought the information to the Consumer Initiative Fund's attention;

- Contact the Project Leader, Assistant Project Leader, or facility where the project is held to obtain additional information and clarify the situation or problem;

- Make a determination about the feasibility of continuing the project.

If the project can be continued using existing project staff without placing an undue burden on them, the project can continue until its continuation causes a burden on remaining staff;

    - Once the Program Coordinator determines that the project should be cancelled in the short run or discontinued permanently:

    - the facility where the project takes place will be notified
    - participants who attend regularly will be notified if contact details are available
    - signs will be posted at the facility to inform participants who may not attend regularly or who have not provided contact details

- Regular payments for services under the Letter of Agreement will be stopped as of the date of the suspension or cancellation determination made by the Program Coordinator;

- One month discretionary funding for Fees may be provided to appropriate individuals, e.g., Project Leader, Assistant Project Leader, etc. by the Consumer Initiative Fund office, at the discretion of the Program Coordinator. See the Discretionary Provision guideline cited earlier in this Handbook.

- The project will be flagged to ensure that continued payments are not made until such time that the project begins operating.

10.4 Managing Unacceptable Behaviour of Clients

The following guidelines apply to conflicts that may arise in the discharge of Project Leader responsibilities. We encourage all Project Leaders to participate with an open mind and a willingness to resolve differences.

This document is a management tool. If the project is based in an agency, the rules of the agency must be followed first and agency staff must be informed of inappropriate conduct.

NOTE: At any time during these procedures, there is always the option of arranging a mediation that would involve the CIF Program Coordinator, the Project Leader, the complainant and a representative from the agency of the facility in which the project is located.
Unacceptable behaviours include:

- Inadequate anger management, disrespectful, rude, or aggressive behaviour
- Fraud or theft
- Racist, sexist or abusive behaviour
- Verbal, physical or sexual harassment
- Failure to take appropriate action in the face of conflict of interest
- Evidence of alcohol or illegal drug use during meetings, project events or workshops
- Very offensive hygiene
- Breaching confidentiality

Procedures to be followed by the Project Leader, or Assistant Project Leader in the absence of the Project Leader:

- 1st Occurrence: Verbal warning issued at the discretion of the Project Leader. This should be done respectfully and as privately as possible. The Project Leader should document the details confidentially.

- 2nd Occurrence: Verbal request, issued at the discretion of the Project Leader, for the participant to leave the project for the day/event. The incident should be reported to the CIF Coordinator

- 3rd Occurrence: 1 month absence from the project activity. The Project Leader has the discretion to issue this in consultation with the CIF Coordinator.

- Mediation: This can be requested by the Project Leader or the participant and can take place after the 1 month absence period. Process will be facilitated by the CIF Coordinator, and agency staff as required.

- 3 month absence: The determination to issue a 3 month absence will be made by the Project Leader, the CIF Coordinator and a representative from any agency involved in the process.

- Long term absence: To be determined by the CIF Program Coordinator and the Coordinator, Consumer Involvement and Initiatives.

Appendix

11.0 Appendix A – VCH Policies Cited in this Handbook

11.1 Hand Hygiene

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

11.2 Information Privacy & Confidentiality

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.

11.3 Standards of Conduct

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

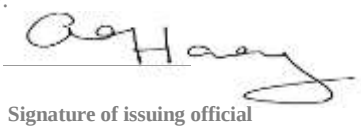
"**Staff**" means staff, employees, researchers, students, volunteers and medical staff who are engaged by VCH;

"**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

11.4 Complaint Management

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).

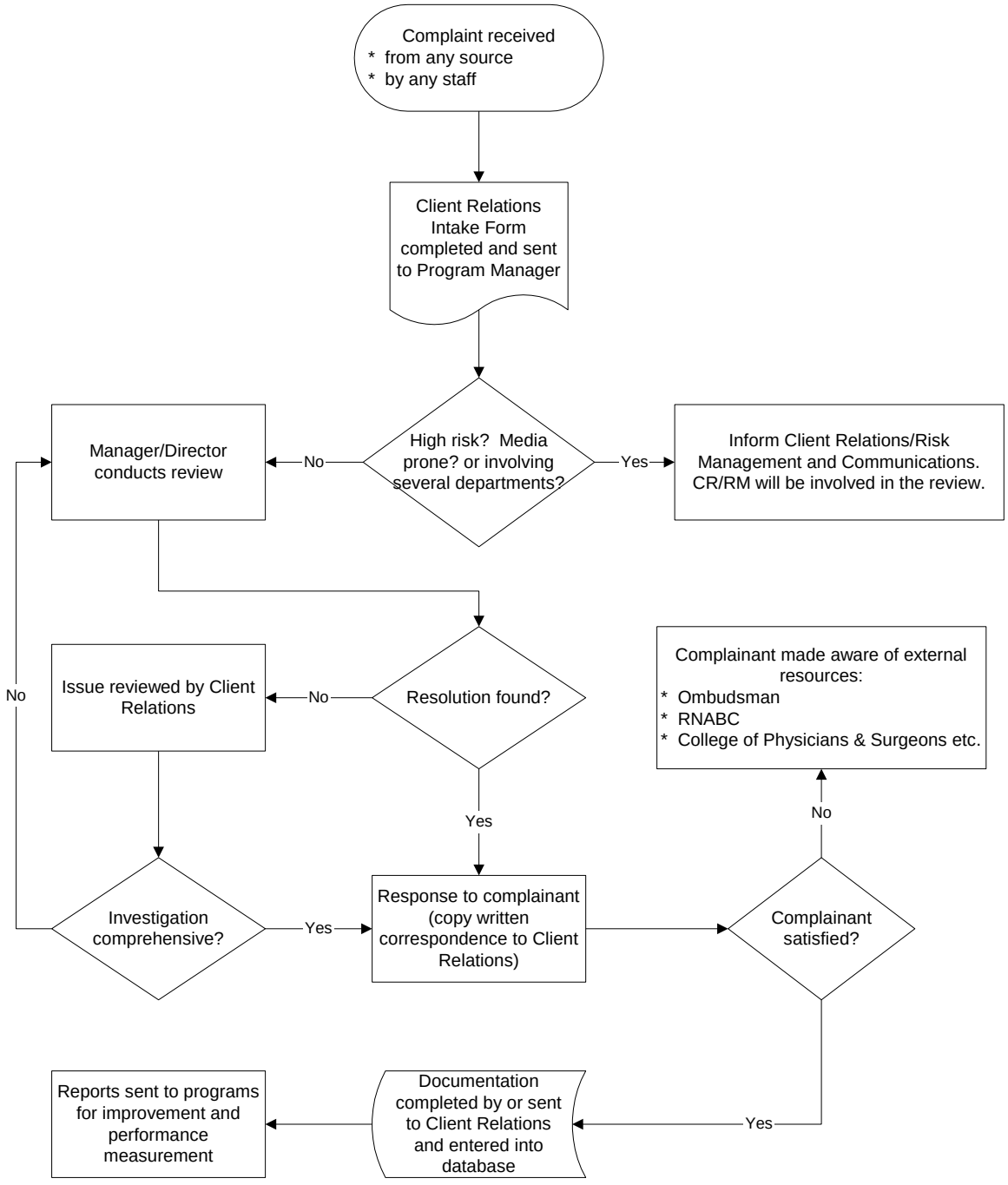
k) **Lost Articles:** concerns raised relating to lost or misplaced personal items during the patient/client's attendance in hospital/departments/clinics.

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

11.5 Respectful Workplace and Human Rights

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

12.0 Appendix B – Other References

12.1 Peer Support Services Agreement FAQ

Peer Support Services Agreement FAQ

Understanding your Contract – Peer Support Service Providers

We would like to welcome you aboard as a Peer Support Services Provider. A Peer Support Services Provider is an individual who has lived experience of mental health/substance use challenges and is being contracted by Vancouver Coastal Health (VCH) as either a Peer Support Worker or a Peer Support Service Provider.

Peer Support Workers are individuals with lived experience of mental illness/substance use who have graduated from a Peer Support Worker Training Program. These individuals are contracted to work one to one with their peers, providing support to achieve personal goals, to learn new skills, and to further connect with community resources. They may also facilitate group work or activities.

Peer Support Service Providers are individuals with lived experience of mental illness/substance use who are contracted to work, usually with their peers, and who may or may not be trained in a Peer Support Workers Training Program. Peer Support Service Providers carry out a wide variety of activities and often engage in group work with their peers. Some examples include managing bursary funds for education and art programs or organizing a choir group.

For the purposes of the contract you are about to review, Peer Support Service Providers are referred to as "Service Providers". This is because you are being contracted by VCH as an individual who is offering services (your lived experience of mental illness and substance abuse) in exchange for payment for these services.

Below you will find some helpful Frequently Asked Questions (FAQs) that may assist in answering common questions or concerns that present while reviewing the contract. For reference purposes, rectangle boxes are displayed on the right column and the number inside corresponds to that specific section of the contract.

1. **Services and Performance**

Q. *Where can I find detailed information regarding VCH policies, guidelines and protocols?* 1.2

A. All applicable policies and guidelines can be found in the Handbook for Contractors with Lived Experience of Mental Illness/Substance Use. This Handbook will be provided to you by your supervisor.

Q. *How often am I likely to have reviews with my Contract Supervisor and how will I be notified of these?* 1.3

A. Reviews will occur at the discretion of your Contract Supervisor. You may be notified in person, by telephone, or e-mail regarding these meetings.

2. **Representations and Warranties**

Q. *What information do I need to provide to VCH as proof of licenses, credentials and qualifications?* 2.2

A. Any licenses credential and qualifications that are required will be outlined in Schedule A, Section 11 of your contract. This is not solely limited to professional qualifications; as an

example, it could also include attending and completing the Peer Support Worker Training Program or the VCH Privacy and Confidentiality Undertaking.

3. Fees, Expenses, and Taxes

Q. *What information do I need to provide as part of my invoice to ensure I receive payment?* 3.1

A. In the Handbook for Contractors with Lived Experience of Mental Illness/Substance Use, you will find a blank Expense Forms and Hours and Payment Sheet. Your Contract Supervisor can review this information with you to ensure you are confident and understand all requirements in order to complete.

Q. *Am I responsible for paying taxes and charges or will VCH cover these costs?* 3.2

A. You will be responsible for paying any applicable taxes. VCH does not pay any taxes, assessments and charges on your behalf. VCH will not contribute to the Canada Pension Plan or Employment Insurance, withhold federal and provincial taxes or provide any other contributions.

4. Term and Termination

Q. *What conflict resolution/mitigation steps will VCH take prior to termination?*

A. Your contract supervisor and coordinator works in your best interest to support in continual feedback and personal improvement. If there are any performance issues, VCH will communicate with you directly to resolve issues and work towards a resolution. 4.2

Service Providers should note that any violation of policies may result in several potential courses of action including a breach of contract, dispute procedures, and/or termination of contract.

5. Confidentiality, Intellectual Property and Personal Information

Q. *Where can I learn more about the Freedom of Information Protection of Privacy Act (FOIPPA) and the Personal Information Protection Act?* 5.4

A. If you have any questions regarding FOIPPA or want to learn more please let your Contract Supervisor know and they will be able to connect you with the VCH Privacy Office (privacy@vch.ca).

6. Insurance and Indemnity

Q. *As a Peer Support Service Provider am I required to obtain my own insurance?* 6.2

A. No, you will not need to obtain your own insurance. VCH will purchase and maintain Commercial General Liability insurance, in the amount of $2,000,000.00 per occurrence insuring against any third party bodily injury, third party property damage, and personal and advertising injury that may occur while you are delivering services.

Q. Am I responsible for paying any insurance deductibles? 6.2

A. Yes, you are responsible for paying the deductible, however the deductible does not apply in all circumstances. The deductible will only apply if there is a property damage claim where the total cost of damage is less than $1,000. The deductible does not apply in the event that the cost of property damage exceeds $1,000. The deductible will never apply in the event of a bodily injury claim.

Q. *As a Peer Services Contractor am I required to have my own WorkSafeBC (WSBC) Coverage?* 6.4

A. No, all Peer Support Service Provider are added to VCH's WorkSafe coverage, which will cover the Peer Support Service Provider for the purposes of the *Workers Compensation Act* (British Columbia). WorkSafeBC will use the term "worker" to identify Peer Support Service Providers as workers; however, this does not mean that the Service Provider is an employees of VCH.

Q. *Am I required to obtain Personal Optional Protection Insurance?* 6.3

A. No, this is not applicable for Peer Support Service Providers.

8. Criminal Record Check

Q. *As a Peer Support Service Provider am I required to obtain a Criminal Record Check before I start work?* 8.1

A. Yes, all Peer Support Service Providers are required to complete a Criminal Record Check (CRC). VCH will cover the cost of the check and will send the appropriate forms to the Ministry of Justice, provided the appropriate sections on the form have been filled out by the Service Provider.

The Service Provider will be able to begin work once the CRC application is in process. However, you will be required to stop working if you fail to comply with a request related to the application process or are deemed a risk under the corresponding legislation. If the results of a CRC show that you do not present a risk of physical or sexual abuse to children or a risk of physical, sexual, or financial abuse to vulnerable adults, then you will be allowed to continue working. Decisions regarding this are made by the Ministry of Justice.

The criminal record check is to be done through the Ministry of Justice. It is valid for 5 years of working with children and/or vulnerable adults. The requirements for working with vulnerable adults are more stringent.

9. Independent Contractor

Q. *By signing this agreement, am I now an employee of VCH?* 9.1

A. No, the Peer Support Service Provider acts as an independent contractor and there is no employment relationship between VCH and the Service Provider. The Service Provider cannot enter into contracts or other legal commitments on behalf of VCH.

10. Assignment and Subcontracting

Q. *What does it mean to subcontract services and am I eligible to do this?* 10.1

A. Subcontracting is when you allocate a certain portion of your work to another person or party. As the work you are being contracted to do is on an individual and group basis and due to your lived experience, there are no opportunities for a Service Provider to subcontract out.

Sub-contracting does not include shift swapping or having another Peer Support Service Provider cover your shift if you are unable to attend. This should be a discussion with your contract supervisor.

11. Conflict of Interest

Q. *I am not sure if I have a conflict of interest – who can I speak to about this to learn more?* 11.1

A. If you think you may have a conflict of interest or have a question regarding ethical standards, please contact your Contract Supervisor to discuss this issue further.

12. Notices

Q. *Is it considered notice if my Contract Supervisor communicates with me verbally that the terms of my agreement are going to change or that my contract is going to be extended for another year?* 12.1

A. A verbal notice must be followed up by a formal written notice. Correspondence related to ending or modifying an agreement must be made in a way that is trackable by both parties.

Schedules

A. ***Services and Additional Terms*** – this section outlines the details of exactly what services you are committed to delivering, where you will be delivering those services and any other accountabilities you will uphold as a Service Provider contracted by VCH.

B. **Payment** - this section outlines your payment rate from VCH, and details regarding where to submit your invoices and timelines for when you will receive payment.

C. **Insurance** – this section outlines the insurance coverage provided by VCH and includes information regarding additional insurance coverage that may need to be obtained by the Service Provider (i.e. Automobile Liability Insurance if driving is a part of your role).

D. ***Privacy Undertaking*** – this undertaking details the Privacy and Confidentiality terms you are required to adhere by as a Service Provider.

If you have any further questions regarding your contract or role, please contact your Contract Supervisor.

12.2 The VCH Privacy Undertaking and our Contractors

The VCH Privacy Undertaking and VCH's Contracted Service Providers

As a leader in Community Care, VCH's role is to ensure that measures are in place to protect the clients that use our services. Although the addition of new technologies to our healthcare system improves continuity of care and information storage, it also introduces greater potential for privacy breaches. It is within the contract managers' responsibilities to ensure that the service providers with whom VCH contracts have a clear understanding of and are following the ***VCH Privacy and Confidentiality Policy*** to the best of their ability.

In an effort to provide privacy education for contracted service providers with respect to protecting patient information, the Privacy Office in collaboration with the Commercial Initiatives Team is encouraging all service provider personnel to complete the online VCH Privacy and Confidentiality Undertaking. By doing so, staff and clients involved in VCH's Community care services can feel confident that the contracted service providers understand the details of the VCH Privacy and Confidentiality Policy and implement appropriate safeguards to protect client information.

Frequently Asked Questions:

How long does the Confidentiality Undertaking take to complete?	The VCH Privacy and Confidentiality Undertaking should take less than 10 minutes to complete.
Who is responsible for monitoring service provider compliance?	The Privacy Schedule of the contract states that VCH may request the service provider to conduct specific ongoing training for its personnel regarding compliance with FIPPA and the Privacy Schedule. This is particularly important if service provider personnel have access to client personal information. Contract managers will be responsible for *reminding* service providers of this requirement annually, during any performance reviews or check-in meetings. Since this is not a primary compliance requirement outlined in the contract, contract managers will not be responsible for collecting any documentation. Service providers are encouraged to keep copies of the signed undertaking on file (either paper or electronic copies), as proof of completion.

Who needs to complete the VCH Privacy and Confidentiality Undertaking?	Service provider personnel include any casual staff, volunteers and/or subcontractors who will be involved in the delivery and/or administration of the contracted services.
How often does this have to be done by service providers?	The VCH Privacy and Confidentiality Undertaking is expected to be repeated by service provider personnel every two years. New hires should complete the Undertaking as part of their onboarding process with the service provider.
How do service providers access VCH Privacy and Confidentiality Undertaking?	Follow the steps below: • Access the Privacy Undertaking on the Learning Hub by going to https://learninghub.phsa.ca/ . • Create a Learning Hub Account using the "Affiliate/Contractor" option when prompted. • Search for course code #11990 or "VCH Privacy and Confidentiality" and click Register course to begin. • Upon completion, print a copy of the signed Privacy Undertaking form and keep a copy on file. For more privacy information, contact VCH Information Privacy Office at privacy@vch.ca or call 604-875-5568.

To further assist service providers in fulfilling this request and understanding their privacy requirements, CIT's Compliance Coordinator is working with the VCH Community Privacy Advisor to create an interactive education workshop for contracted service providers. This education session will be created following an initial assessment to gauge the current state of service provider knowledge. Once we have a better understanding of gap areas, VCH Privacy will offer a series of workshops to the service providers to address any areas of need and improve privacy awareness. Moving forward, this assessment will provide assistance when onboarding new service providers and verifying that their protocols meet the requirements of VCH Privacy prior to accepting VCH clients. The pilot phase of this assessment and education workshop will begin in August 2018.

For any further questions regarding the development of this service provider privacy assessment or the VCH Privacy and Confidentiality Undertaking, please contact the author.

Sami Sekhon
Project Coordinator
Commercial Initiatives Team

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604-829-2567
sami.sekhon@vch.ca

13.0 Appendix C – Peer Contractor Forms

13.1 Orientation Checklist for Peer Contractors With Lived Experience Working in VCH Mental Health and Substance Use Services

a) Discuss or review:
- Confidentiality - ensure that Confidentiality Statement is completed
- Emergency contacts - ensure that Emergency Contact form is completed
- Ethics and personal relationships
- Complaints
- Respectful workplace behavior and policy
- Safety guidelines of the program the Peer Contractor will be working with, including working alone and entering a client's residence (if applicable)
- Liability and event reporting
- Supervision
- Professional boundaries, e.g.:
    - No therapy; support or program activities only
    - All job duties completed within hours assigned
    - Do not meet a client outside of office hours
    - Policies regarding ethics and personal relationships with clients, etc.

i. Peer Support Workers only:
- Continuity of care
- Documentation and paperwork
    - Activity log (to be completed after each visit)
    - Hours and payment sheet, expense form (if applicable)
    - Goal and outcome sheet
    - Client feedback survey
    - Location on site where paperwork can be completed
    - Submission procedures

ii. Peer Led Workshops Facilitators only:
- VCH Emails and Accounts
- Documentation and paperwork
    - Hours and payment sheet
    - Zoombombing procedure
    - VV Attendance Procedure (if applicable)
    - VV Support Group Checklist (if applicable)
    - FAN Backup Facilitator Procedure (if applicable)
    - FAN Attendance Procedure (if applicable)
    - Submission procedures

b) Complete the Letter of Agreement, discussing such items as:
- Absence from duties

i. Peer Support Workers only:
- Notice of a cancelled appointment
- Discretionary payments

c) Orient the Peer Contractor to:
- The program mandate
- Different program members and their roles/responsibilities
- The program environment
- Workforce Development Survey (will be emailed by appropriate Peer Coordinator)

i. Peer Support Workers only:
- Monthly education meeting with the Peer Support Coordinator
- Monthly team meetings
- Discretionary payments

ii. Peer Led Workshops Facilitators only:
- Monthly or quarterly team meetings (as applicable)
- FAN Facilitator USB drive (FAN only)
- VCH Computer Access Instructions (FAN only)
- Workshop materials (FAN only)
- VV Facilitator binder (VV only)
- Feedback Surveys

_____ _____

Signature, Contractor Signature, Contract Supervisor

_____ _____

Printed Name, Contractor Printed Name, Contract Supervisor

Date: _____

13.2 Confidentiality Statement

Contractors with Lived Experience Working in VCH Mental Health and Substance Use Services

- I have read the VCH Policy on Information & Confidentiality.
- I understand and agree that in the performance of my duties as a contractor with VCH, I must hold client and administrative information in confidence.
- Further, I understand that intentional or unintentional violation of this confidentiality may result in termination of my contract.

_____ _____

Date Contractor Name (Please print)

_____

Signature: Contractor

_____ _____

Date Team/Unit/Program

_____ _____

Contract Supervisor Title

_____

Signature: Contract Supervisor

Copy to: Contract Supervisor

Copy to: Consumer Involvement and Initiatives, 520 West 6th

13.3 Emergency Contact Form

Vancouver CoastalHealth
Promoting wellness. Ensuring care.

EMERGENCY CONTACT FORM

Name of Contractor: _____

Name of Emergency Contact (required): _____

Relationship to Contractor (required): _____

Phone Number(s) (required):_____ _____

Other Contact Information (e.g., e-mail address) (optional):

_____

_____

I consent to having Vancouver Mental Health Services contact the above mentioned emergency contact in the event of an emergency or concern for my well-being.

Signature:_____ Date: _____

Print name: _____

Witnessed by:

Signature:_____ Date: _____

Print name: _____

Copy to: Contract Supervisor

13.4 Contract Review

Contract Review

Time Frame:_____ **Review Date**: _____
Contractor:_____ **Program**: _____

This Contract Review is part of your ongoing process of continual feedback and improvement. It provides you with an opportunity to receive and give feedback to/from your Contract Supervisor on your contract performance in relation to program principles and goals. The review allows you and your Contract Supervisor to recognize and enhance your roles, responsibilities and deliverables and to plan performance enhancement.

ROLES, RESPONSIBILITIES AND DELIVERABLES AS SET OUT IN THE CONTRACT	Does not meet contract expectations	Meets contract expectations	Exceeds contract expectations
Communication Skills			
Communicates and interacts positively and effectively	☐	☐	☐
Verbal and written communication is clear	☐	☐	☐
Listens actively to others	☐	☐	☐
Work Habits			
Manages time productively	☐	☐	☐
Punctual for visits and meetings	☐	☐	☐
Works well independently	☐	☐	☐
All contract deliverables performed within hours assigned	☐	☐	☐
Completes required paperwork effectively and in a timely manner	☐	☐	☐
Relationships			
Provides support to clients	☐	☐	☐
Relates to others in a positive way	☐	☐	☐
Codes of Conduct Abides by:			
Personal Relationships	☐	☐	☐
Entering a Client's Residence	☐	☐	☐
Continuity of Care (PSW only)	☐	☐	☐
Confidentiality	☐	☐	☐
Peer Support Workers Only	☐	☐	☐
Meets with clients and supports them to achieve goals	☐	☐	☐
Abides by guidelines specific to Peer Support Workers	☐	☐	☐
Works collaboratively with the interdisciplinary team	☐	☐	☐

Summary of Contract Review (by Contract Supervisor)

Contractor Comments:
Please include comments on your performance. Include ideas on how your Contract Supervisor can support your success in the contract.

☐ I have read and accept this contract review		☐ I have read and disagree with this contract review	
Contract Supervisor's name:		Contractor's name:	
Signature:		Signature:	
Date:		Date:	

14.0 Appendix D – Peer Support Worker Forms

14.1 Goals and Outcomes Form

PEER SUPPORT PROGRAM GOALS & OUTCOMES

CLIENT NAME	D.O.B. (yr.mo.dy.)
PEER SUPPORT WORKER	THERAPIST

GOAL(S) (Therapist/rehab staff's reason for referral to PSW)	DATE:

OBJECTIVES AND PLAN (Developed by client, therapist/rehab staff and PSW)	DATE:
	A.
	B.
	C.

CLIENT'S SIGNATURE

PEER SUPPORT PROGRAM
GOALS & OUTCOME SHEET

OUTCOME/SUMMARY

OUTCOME (Notes by PSW – was the goal achieved accomplishments, strengths and areas of difficulty	DATE:

RECOMMENDATIONS (OPTIONAL)	

OUTCOME SCALE	OBJECTIVES	(1) Not Much Progress	(2) Satisfactorily Achieved	(3) Exceeded Expectations
	A			
	B			
	C			

PEER SUPPORT WORKER SIGNATURE	THERAPIST'S/REHAB STAFF SIGNATURE

14.2 Activity Log

PEER SUPPORT PROGRAM ACTIVITY LOG

GOAL:	
CLIENT'S INITIALS:	**DATE:**

DATE	ACTIVITIES/SIGNIFICANT INFORMATION	DATE OF NEXT VISIT

TO BE COMPLETED BY THERAPIST OR REHAB STAFF ONLY

CLIENT NAME	D.O.B.	PSW	THERAPIST	DATE

14.3 Hours and Payment Form - 1-1

Vancouver CoastalHealth

Hours and Payment Sheet

VCMHS Peer Support Program (1-1)

Section A *(to be completed by the peer support worker, and submitted to their supervisor.)*

Peer Support Worker Name	*Cost Centre Number*	*Month*
	75103005-625-8601505	

Address to send cheque:	*Direct Deposit* ☐

Date (dd/mmm/yy)	# of hours	Activities

Total hours billed: 0	*Allotted monthly hours:*	*Hourly rate: $*	*Group form attached:* ☐

		$ 0.00
PSW signature certifying peer support time	*Team/Unit*	*Total*

Section B *(to be completed by the PSW's supervisor)*

Name (please print)	*Signature*	*Date*	*Team/Unit*

Original to Accounts Payable Copy to Site PSW file Copy to Peer Support Worker

14.4 Hours and Payment Form – Groups

Vancouver CoastalHealth

Hours and Payment Sheet

VCMHS Peer Support Program (Groups)

Section A *(to be completed by the peer support worker, and submitted to their supervisor.)*

Peer Support Worker Name	*Cost Centre Number*	*Month*
	75103005-625-8601505	
Address to send cheque:		*Direct Deposit* ☐

Date (dd/mmm/yy)	# of clients	# of hours	Group Name	Date (dd/mmm/yy)	# of clients	# of hours	Group Name

Total hours billed: 0	*Allotted monthly hours:*	*Hourly rate: $*	*1-1 form attached:* ☐

		$ 0.00
PSW signature certifying peer support time	*Team/Unit*	*Total*

Section B *(to be completed by the PSW's supervisor)*

Name (please print)	*Signature*	*Date*	*Team/Unit*

Original to Accounts Payable Copy to Team/Unit PSW file Copy to Peer Support Worker

Updated Sept 2021

14.5 Expenses Form

PSW Expenses Form

VCH Peer Support Program

Instructions: Not to exceed -$ **Original Receipts** must be attached. Claim form must be signed by VCMHS PSW supervisor.

Section A ***(to be completed by the peer support worker, and submitted to their supervisor.)***

Peer Support Worker Name	*Site*	*Cost Centre Number*	*Claim for the Month(s) of*

Date	*Description of Expense*	*Amount*	*Date*	*Description of Expense*	*Amount*
		$			$
		$			$
		$			$
		$			$
		$			$
		$			$
		$			$
		$			$
		$			$
		$			$
		$			$
		$			$
		$			$
		$			$
		$			$
		$			$
		$			$
		$			$

PSW signature certifying expenditures for peer support work only	*Received by*	*Date*	**Total**	$

Section B ***(to be completed by the PSW's supervisor)***

Checked and approved for payment by:	*Date*

Original and Receipts to Accounts Payable
Copy to Peer Support Worker
Copy to Team/Unit PSW file

14.6 SLS event reporting – Contractors with Lived Experience

Follow this procedure when:

A. Harm resulting in emotional or physical harm to the client or the client experiences a theft or property damage

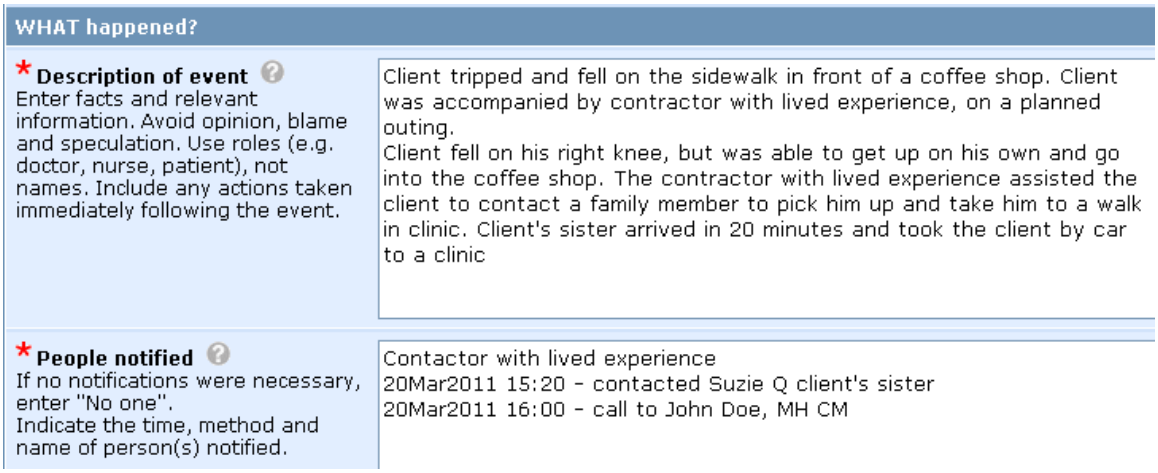
If a contractor with lived experience is with a client when an incident occurs, and the client's harm is emotional or physical or the client experiences theft or damage of their property:

- Incident must be reported as soon as possible to the staff member responsible for the client and the Contract Supervisor
- Incident must be reported in SLS by the staff member responsible for the client or the Contract Supervisor

Site – Choose the facility where staff member who is responsible for the client works

Description of the Event – Include in the detailed description that the client was accompanied by "contractor with lived experience"

People notified – include the people that the contractor with lived experience has notified



About you – Your Program: choose Mental Health Rehabilitation

B. The contractor is injured while carrying out their duties

If the contractor with lived experience is injured while carrying out his or her duties, the Contract Supervisor will contact the Director of Client Relations & Risk Management and the Manager of Consumer Involvement and Initiatives.
No employee event report is to be filed.

15.0 Appendix E – Peer Led Workshops Facilitator Forms

15.1 FAN Forms

15.1.1 Hours and Payment Form – FAN Facilitators

#200-520 West 6th Avenue,
Vancouver, B.C. V5Z 4H5
Fax: 604-874-7661
Attention: Celina Ambrosio

PEER LED WORKSHOPS
Fee & Expense Request Form

Group Name: FAN **Month of:**

Name: **Date submitted:**

DATE	GROUP/ WORKSHOP	HOURS	RATE($)	TOTAL($)
			FEES TOTAL:	
			**Expenses/submitted with original itemized receipts attached:	
			FEES and EXPENSES TOTAL:	

Finance Department requires ORIGINAL ITEMIZED RECEIPTS ONLY. Thank you.

Signed: _____ Date: _____

Celina Ambrosio, Coordinator,
Peer Led Workshops

15.1.2 FAN Zoombombing Procedure

FAN Zoombombing Protocol

In the event of a Zoombombing:

1. Identify if person is a Zoom Bomber

2. Mute & Disable Video of Zoombomber
    a. To Mute:
    Hover over a participant for options to appear on their rectangle. Click the blue "Mute" button to mute this participant. You can also right click or click the three dots to open a pop-up menu. Click "Mute Audio."
    b. To Disable Video:
    Hover over a participant for options to appear on their rectangle. Click the blue “More” button (or it may look like “…”) and then click the “Stop Video” button.

3. Remove Zoombomber (option to report)
    a. Hover over a participant for options to appear on their rectangle. Click the blue “More” button (or it may look like “…”) and then click the “Remove” button. The “Report” box will be checked. If you do not wish to report them, uncheck the box.

4. If more than 1 Zoombomber, repeat steps 2 & 3

5. If the amount of Zoombombers becomes unmanageable: Lock the meeting
    a. On the menu bar, click on “Security” and then click “Lock meeting”

6. After locking the meeting, if the current attendees are identified as residual Zoombombers, facilitators have the option to Suspend Participant Activities
    a. On the menu bar, click on “Security” and then click on red “Suspend Participant Activities” (last item on the drop-down list)

Once Zoombombers have been removed:

1. Check in with participants
    a. Ask if participants would like to discuss/debrief Zoombombing incident and allow time for this discussion
    b. Ask if participants would like to continue with the meeting as planned
        i. If “yes”, continue meeting
        ii. If unanimous “no”, end meeting and offer optional further support. Participants can contact Celina (Coordinator) at VanPeerWorkshops@vch.ca or 604-708-5274
        iii. If some “yes”, some “no”: offer optional further support from above and then continue meeting with those that wish to stay

After the meeting:

1. Report incident to Celina by email describing what happened and steps taken
    a. Option to call Celina 604-708-5274 to debrief/discuss incident
    b. If meeting takes place on Saturday or Sunday, option to contact the VCH Community Manager-on-call 604-809-0932. There is also an email option for non-urgent issues vcmoc@vch.ca. Please cc Celina in all email communications.
    c. If meeting takes place on a Monday, Tuesday, or when Celina is off (during the week): option to call Sue Macdonald 778-984-0088

2. Take care of you!

15.1.3 FAN Backup Facilitator Procedure

All assigned facilitators (co-facilitators and backup facilitators) are to email their facilitation team by 9:30 AM the day of the session stating whether or not they are able to facilitate that day. Please cc the PLW Coordinator in this email communication. This ensures that the backup facilitator is notified that they are needed to facilitate that day with time to prepare, or that they can go about their day if they are not needed.

15.1.4 FAN Workshop Attendance Procedure

FAN Facilitators will be sent a participant attendance sheet a day or two prior to the start of each workshop.

FAN Facilitators are to track attendance and return to the PLW Coordinator after the first and last sessions of a workshop.

15.2 Voices & Visions Forms

15.2.1 Hours and Payment Form – VV Facilitators

Invoice

Name:

Date

Month & Year

	Job	Payment Terms	Submission Date
	VV Group Facilitator	Due on receipt	

Date	Description	Hourly Rate	Hours	Total
			Fees Total	
			** Expenses / submitted with original itemized receipts attached	
			Fees and Expenses Total	

Signed: ____ Date: ____________________________

Celina Ambrosio,
Coordinator, Peer Led Workshops

Submit to: celina.ambrosio1@vch.ca & CC: peertimesheets@vch.ca

Rate: $20/hour

15.2.2 VV Zoombombing Procedure

VV Zoombombing Protocol

In the event of a Zoombombing:

1. Identify if person is a Zoombomber

2. Mute & Disable Video of Zoombomber
    a. To Mute:
    Hover over a participant for options to appear on their rectangle. Click the blue "Mute" button to mute this participant. You can also right click or click the three dots to open a pop-up menu. Click "Mute Audio."
    b. To Disable Video:
    Hover over a participant for options to appear on their rectangle. Click the blue “More” button (or it may look like “…”) and then click the “Stop Video” button.

3. Remove Zoombomber (option to report)
    a. Hover over a participant for options to appear on their rectangle. Click the blue “More” button (or it may look like “…”) and then click the “Remove” button. The “Report” box will be checked. If you do not wish to report them, uncheck the box.

4. If more than 1 Zoombomber, repeat steps 2 & 3

5. If the amount of Zoombombers becomes unmanageable: Lock the meeting
    a. On the menu bar, click on “Security” and then click “Lock meeting”

6. After locking the meeting, if the current attendees are identified as residual Zoombombers, facilitators have the option to Suspend Participant Activities
    a. On the menu bar, click on “Security” and then click on red “Suspend Participant Activities” (last item on the drop-down list)

Once Zoombombers have been removed:

1. Check in with participants
    a. Ask if participants would like to discuss/debrief Zoombombing incident and allow time for this discussion
    b. Ask if participants would like to continue with the meeting as planned
        i. If “yes”, continue meeting
        ii. If unanimous “no”, end meeting and offer optional further support. Participants can contact Celina (Coordinator) at VanVoicesAndVisions@vch.ca or 604-708-5274
        iii. If some “yes”, some “no”: offer optional further support from above and then continue meeting with those that wish to stay

After the meeting:

1. Report incident to Celina by email describing what happened and steps taken
    a. Option to call Celina 604-708-5274 to debrief/discuss incident
    b. If meeting takes place on Saturday or Sunday, option to contact the VCH Community Manager-on-call 604-809-0932. There is also an email option for non-urgent issues vcmoc@vch.ca. Please cc Celina in all email communications.
    c. If meeting takes place on a Monday, Tuesday, or when Celina is off (during the week): option to call Sue Macdonald 778-984-0088

2. Take care of you!

15.2.3 VV Support Group Attendance Procedure

Recovery College YVR (RC YVR):

Voices & Visions Attendance Procedure

Facilitators' emails will be assigned to RC YVR website's back-end registration for each event (aka group). Facilitator emails are *not* visible on the front-end of the RC YVR website and are *not* shared with participants.

Please follow the instructions below regarding tracking attendance for Voices & Visions Groups.

Before Groups:

1. Receive email notification when a participant registers for an event (group)
2. Add participant to attendance list

During Groups:

3. Take attendance (using the attendance list created by received registration emails)
    a. For participants that are not registered:
        i. Add to attendance list using their name (if they are comfortable sharing it), OR
        ii. Add to attendance list using the pseudonym, "VV Attendee"
4. Encourage all participants to register for VV groups they plan to attend via https://recoverycollegeyvr.ca/ (participants are still welcome to attend even if they do not register)

After Groups:

5. Send attendance to Celina (Celina.Ambrosio1@vch.ca) and VanVoicesAndVisions@vch.ca

Questions, comments, and/or concerns can be sent to:
Celina.Ambrosio1@vch.ca or VanVoicesAndVisions@vch.ca.

2023.05.05

15.2.4 VV Support Group Checklist

Voices and Visions Support Group

Facilitator Checklist

Please be sure to do the following at each meeting:

- ☐ Acknowledge whose land we are on.
- ☐ Go over highlights from group guidelines. Make sure each participant has a copy. Ask participants if they want to change the guidelines or have additional guidelines.
- ☐ When you do introductions, be sure to ask people their pronouns. Share your own to model (ie. she/her, he/him, they/them).
- ☐ Pass out evaluations at the end of the session and collect them.
- ☐ Make resource materials available for borrowing and have the resource sign out sheet currently in use available.
- ☐ After the session is finished, transfer all paperwork to the Voices and Visions Binder or designated storage spot.
- ☐ Alert PLW Coordinator (604-708-5274) if the site is short on articles or any of the forms.
- ☐ Alert PLW Coordinator if completed evaluation forms are piling up and need collecting (will aim to collect every month).

Thank you!

15.3 Zoom Guide

Zoom
Step-by-Step Guide for CI&I Group Facilitators

Prep: Have any documents you wish to show, such as group guidelines, open, but minimized on your computer.

Getting Started

- Log into the Zoom account you will be using. You can do this by going to zoom.us via your web browser and logging in with the account credentials you have been provided with.
- The meeting should already have been booked for you and will be set up to include a wait room with participants muted until you unmute them. This is for security purposes.
- Shortly before you want to start your meeting, log in to zoom.us. Click on ACCOUNT. Choose START MEETING. If your are using a computer, it will be a large blue button on the right side of the screen.
- Once you are logged in, you may need to click on the box-like icon on the upper right side of the meeting windoow in order to maximize it.

Managing Participants + Setting Hosts & Co-hosts

- Click on MANAGE PARTICIPANTS. It is one of the options at the bottom of the window. A list of all the participants in your waiting room will show up on the right-hand side of your screen.
- By each person's name who is in the waiting room, there will be an ADMIT button. Don't admit everyone just yet. Set your CO-HOST OR HOST first. You can only have one HOST, but can have multiple CO-HOSTS.
- The person who started the meeting will initially be the HOST. Take a look at the participants listed. Admit anyone you want to make a CO-HOST or HOST. Hover your cursor over their name until the MORE button appears. Clicking on that will allow you to make someone a HOST or CO-HOST.
- For other partiipants, you can either choose to admit them one-by-one via the ADMIT button beside their name, or you can choose ADMIT ALL via the button on the top of the participant list.
- Late participants will show up as they arrive. You can choose ADMIT beside their name as they come.
- Choose to UNMUTE participants via your participant list. Remember to UNMUTE late arrivals manually. This may involve clicking on the crossed out microphone beside their name.
- You are now ready to start your meeting!

Showing documents like group guidelines

- Start by selecting SHARE SCREEN, which appears at the bottom of your meeting window. To share a file, like group guidelines, just have the document open on your computer. It will show up on the SHARE SCREEN options. You can then choose it.
- To stop sharing a document, choose the STOP SHARE option listed at the top of your screen.
- When you go over group guidelines, be sure to ask participants to be in a private space as they take part in your meeting in order to protect confidentiality. We don't want non-participants walking into the room they are in and inadvertantly hearing other participants sharing.
- Also, do not record meetings.

Dealing with deliberate disruption

- If someone in the group is being deliberately disruptive (sometimes called "zoombombing"), simply move them from the meeting into the wait room. Moving them into the wait room will appear as an option under MORE when you hover over their name.

Ending the Meeting

Best wishes for a wonderful gathering!