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HEALTH AND SAFETY POLICIES

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ALCOHOL AND DRUGS POLICY

Alcohol and drug abuse poses a threat to the health and safety of our employees and to the security of our clients. For these reasons, the Kanesatake Health Center is committed to the elimination of drug and alcohol use and abuse in the workplace.

Employees should report to work fit for duty and free of any adverse effects of drugs or alcohol.

This policy does not prohibit employees from the lawful use and possession of prescribed medications. Employees must, however, consult with their doctors about the medications' effect on their fitness for duty and ability to work safely, and they must promptly disclose any work restrictions to their supervisor.

Whenever employees are working, on KHC premises or offsite, they are prohibited from:

a. Using, possessing, buying, selling, manufacturing or dispensing drugs.
b. Being under the influence of alcohol or drugs as defined in this policy.
c. Possessing or consuming alcohol.

Working under the influence

The Kanesatake Health Center has the responsibility to provide and maintain a healthy and safe work environment for all employees and clients. Consequently, if an employee shows up to work and is deemed to be impaired by alcohol or drugs, he/she will be sent home without pay.

Employee Assistance

The Kanesatake Health Center will assist and support employees who voluntarily seek help for drugs or alcohol problems. Such employees will be allowed to use accrued paid time off, placed on leaves of absence and referred to treatment resources.

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ANTI-HARASSMENT& DISCRIMINATION POLICY

The Kanesatake Health Center Inc. is committed to fostering a harassment/discrimination-free workplace where all employees are treated with respect and dignity. Employees who are found to have harassed another individual may be subject to disciplinary action. This includes any employee who interferes with the resolution of a harassment /discrimination complaint or retaliates against an individual for filing a harassment /discrimination complaint

The Canadian Human Rights Act protects employees from harassment /discrimination based on race, national or ethnic origin, color, religion, age, sex, sexual orientation, marital status, family status, disability or pardoned conviction.

PRINCIPLES

This policy applies to all current employees of the Kanesatake Health Center Inc. including full and part-time, casual, contract, permanent and temporary employees. This policy also applies to clients, visiting professionals, community members and the Board of Directors.

This policy applies to all behavior that is in some way connected to work, including during off-site meetings, training and on business trips.

DEFINITIONS

Discrimination is:

- An action or a decision, imposing extra burdens or denying benefits to a person for reasons such as their race, national or ethnic origin, colour, religion, age, sex, sexual orientation, gender identity or expression, marital status, family status, disability, genetic characteristics, or a conviction for which a pardon has been granted or a record suspended. These reasons are protected under the Canadian Human Rights Act. Discrimination may be intentional or not.

Harassment (a form of discrimination) is:

- offending or humiliating someone, physically or verbally threatening, or intimidating someone; or

- making unwelcome jokes or comments about someone's race, national or ethnic origin, colour, religion, age, sex, sexual orientation, gender identity or expression, marital status, family status, disability, genetic characteristics or pardoned conviction.

Sexual harassment is:

- Offensive or humiliating behavior that is related to a person's sex;
- Behavior of a sexual nature that creates an intimidating, unwelcome, hostile or offensive work environment; or
- Behavior of a sexual nature that could reasonably be thought to put sexual conditions on a person's job or employment opportunities.

OBJECTIVES

Kanesatake Health Center Inc. is responsible for providing all employees a discrimination and harassment-free workplace.

RESPONSIBILITIES AND EXPECTATIONS

The Executive Director is responsible for

- ensuring that this policy is applied in a timely, consistent and confidential manner;
- determining whether or not allegations of harassment /discrimination are substantiated; and;
- determining what corrective action is appropriate where a harassment/discrimination complaint has been substantiated.
- the administration of this policy;
- reviewing this policy annually, or as required; and
- making necessary adjustments to ensure that this policy meets the needs of the organization.

Supervisors are responsible for:

- fostering an environment free from harassment and discrimination;
- leading by example about appropriate workplace behavior;
- communicating the process for investigating and resolving complaints made by employees;
- dealing with harassment or discrimination situations immediately upon becoming aware of them, whether or not a complaint has been made;

- taking appropriate action during an investigation, including separating the parties to the complaint, when appropriate; and
- ensuring situations are dealt with in a sensitive and confidential manner.

Employees are responsible for:

1. treating others with respect in the workplace;
2. reporting harassment /discrimination to their supervisors;
3. cooperating with a harassment investigation and respecting the confidentiality related to the investigation process;

Employees can expect:

- to be treated with respect in the workplace;
- that reported harassment/discrimination will be dealt with in a timely, confidential and effective manner;
- to have their rights to a fair process and to confidentiality respected during a harassment/discrimination investigation; and
- to be protected against retaliation for reporting harassment/discrimination or cooperating with an investigation.

COMPLAINT PROCEDURES

An employee may file a harassment or a discrimination complaint by contacting the Executive Director. The complaint may be verbal or in writing. If the complaint is made verbally, the Executive Director will record the details provided by the employee.

The employee should be prepared to provide details such as what happened; when it happened; where it happened; how often and who else was present to witness (if applicable).

Complaints should be made as soon as possible but no later than within 6 months of the last incident of perceived harassment/discrimination, unless there are circumstances that prevented the employee from doing so.

The Executive Director will inform the person that the complaint has been made against, in writing, that a complaint has been filed. The letter will also provide details of the allegations that have been made against him or her.

Every effort will be made to resolve the harassment complaints within 30 days. The Executive Director will advise both parties of the reasons why, if this is not possible.

All parties to a complaint are expected to respect the privacy and confidentiality of all other parties involved and to limit the discussion of a harassment complaint to those that need to know.

If either party to a harassment complaint believes that the complaint is not being handled in accordance with this policy, he or she should contact the Board of Directors.

MEDIATION

Wherever appropriate and possible, the parties to the harassment complaint will be offered mediation prior to proceeding with an investigation.

- Mediation is voluntary and confidential. It is intended to assist the parties to arrive at a mutually acceptable resolution to the harassment complaint.
- The mediator will be a neutral person, agreed upon by both parties. The mediator will not be involved in investigating the complaint.
- Each party to the complaint has the right to be accompanied and assisted during mediation sessions by a person of their choosing.

INVESTIGATION

If mediation is inappropriate or does not resolve the issue, a harassment or discrimination investigation will be conducted. All investigations will be handled by an individual who has the necessary training and experience, an external consultant may be engaged for this purpose.

The investigator will interview the person who made the complaint, the person the complaint was made against and any witnesses that have been identified. All people who are interviewed will have the right to review their statement, as recorded by the investigator, to ensure its accuracy.

The investigator will prepare a report that will include:

- a description of the allegations;
- the response of the person the complaint was made against;
- a summary of information learned from witnesses (if applicable); and
- a decision about whether, on a balance of probabilities, harassment or discrimination did occur.

This report will be submitted to the Executive Director. Both parties to the complaint will be given a copy.

SUBSTANTIATED COMPLAINT

If a harassment/discrimination complaint is substantiated, the Executive Director will decide what action is appropriate. Remedies for the employee who was harassed/discriminated may include:

- an oral or written apology;
- compensation for lost wages and any lost employment benefits such as sick leave; and;
- compensation for hurt feelings.

Corrective action for the employee found to have engaged in harassment/discrimination may include:

- a written reprimand;
- a suspension;
- dismissal.

Both parties to the complaint will be advised, in writing, of the decision.

OTHER REDRESS

An employee who is not satisfied with the outcome of the harassment/discrimination complaint process may file a complaint with the Canadian Human Rights Commission.

PRIVACY AND CONFIDENTIALITY

All parties to a harassment/discrimination complaint are expected to respect the privacy and confidentiality of all other parties involved and to limit the discussion of the complaint to those that need to know.

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The Kanesatake Health Center and all individuals involved in the harassment/discriminaiton complaint process, will comply with all requirements to protect personal information.

REVIEW

The Kanesatake Health Center Inc. will review this policy and procedures on an annual basis, and will make necessary adjustments to ensure that it meets the needs of all employees.

ENQUIRIES

Enquiries about this policy and related procedures can be made to the Board of Directors and/or the Executive Director.

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CRISIS PROTOCOL POLICY

POLICY STATEMENT:

There is zero tolerance for violence at the Kanesatake Health Center or any place where Health activities or services are being delivered. Nevertheless, it is important that staff who intervene in crisis situations do so in a way that positively influences an immediate resolution of the crisis.

PROCEDURES:

1. USE OF PANIC BUTTONS:

There are panic buttons connected to our alarm security system.

- There are four permanent panic buttons and six mobile panic buttons. The permanent ones are installed in the visiting professional's office, the examining room, the reception area and the kitchen (for reference please see map in appendix).
- The six mobile units are for workers to use when they are seeing clients in their offices. Three have been permanently assigned to the mental health offices. (see map in appendix)
- The security company cannot detect where the mobile units are when they are pressed. Therefore, the three mobile units will remain at reception area and it is the RESPONSIBILITY of each team member who takes a mobile unit to an office to ENSURE that it is signed out with the appropriate information (where you will be, your name, time, date and panic button number) duly noted in the sign in/sign out book to this effect. THIS IS EXTREMELY IMPORTANT. IF WE DO NOT KNOW WHERE YOU ARE, WE WILL HAVE TO SEARCH THE BUILDING.
- The alarm security company will notify the Sureté Québec and the Kanesatake Health Center when a panic button has been pressed.
- The Sureté will respond immediately by calling us for details. If need be they will come to the Kanesatake Health Center to either assist the team, assume responsibility with the crisis at hand or wait as back-up. This will depend on the nature of the crisis.
- There should be one team member designated to provide the necessary information to the police officer in charge of the call.

- It is the responsibility of the designated team member to give as accurate an assessment as possible to the police officer in charge of the call. The Sureté and the designated team member will decide on the best course of action to take. The objective is always to MINIMIZE RISK TO PHYSICAL AND EMOTIONAL HARM to everyone on site.
- The panic button should NOT take the place of the other sections of this policy. It is an additional resource to the policy in place that should be used only in extreme high-risk situations when you believe there is no other course of action available.
- Remember to return the mobile unit to the reception area. Duly note its return in the designated book **as soon as your session is over**.
- Remember to follow all other procedures in this policy including ensuring the safety of any community members in the building by having a clear exit plan in place in the event the Sureté need to use force to remove a client once the panic button has been pressed.

2. DESIGNATED TEAM MEMBER

The role of the designated team member is to ensure the well-being of individuals in crisis, while maintaining the safety of clients, self, colleagues and the organization. When a designated team member is needed:

- as much as possible, she/he should be someone with adequate experience in diffusion techniques and crisis intervention;
- be the most confident and centered at the time;
- may be the first on the scene of the crisis;
- may have the strongest rapport with the individual(s) in crisis;
- she/he will assess the situation and plan the intervention;
- she/he will coordinate the team response including any backup needed from elsewhere;
- she/he may talk or communicate directly with the individual(s) in crisis.

N.B. it may be necessary or advantageous to change the designated team member. If so, this needs to be explained to or negotiated with the client(s) and all team members need to be aware of the change and the impact on their roles and responsibilities.

3. HIGH- RISK CLIENTS

When staff know that they have appointments to be held at the Health Center with high-risk clients they will:

- Inform the reception worker (in advance of the client's arrival) of the nature of the risk, the steps they wish to have taken and who else should be notified in the building to minimize any problems.
- MAKE A CLEAR PLAN OF ACTION.
- SIGN OUT A MOBILE PANIC BUTTON FOR ADDITIONAL SECURITY.
- If deemed appropriate, inform team members of the nature of the risk and the steps they wish to have taken to minimize any problems.
- Have a designated team member take the leadership role to coordinate any necessary actions.
- Inform reception and team members when the client has left so that everyone will know that the crisis alert is over.
- If a crisis ensues, use your crisis intervention training and assess the necessity to involve others or use the panic button to diffuse the situation.
- Write up an incident report (and suicide or crisis alert form if necessary) as soon as possible to ensure accurate reporting of the facts.

5. CRISIS-LIKE BEHAVIOR

When staff do not have advance knowledge of a client's risk levels and they hear or see something that is perceived to be crisis-like behavior, they will:

- Have a designated team member take the leadership role to coordinate any necessary actions.
- Check in with the co-worker who is with the client in question. This can be done by phone or by actually going to see if everything is under control. **Never** assume that a co-worker does not need help if they do not ask for it or are not able to show any non-verbal clues. Be clear (ex. is everything okay here?). If the worker seems reluctant to answer in a straightforward manner, use coded messages if need be (ex. should I have your calls held for a certain time limit?).
- Check it out and inform others in the building of the potential for providing support to the co-worker and/or client in question as well as to any visitors in the building. Make a plan of action together with all team members in the building. Even if everything is deemed to be okay, inform other team members who may have heard or seen the same thing. This will avoid unnecessary interruptions for the worker and client.
- Use the panic button if absolutely necessary and if you have access to one without putting yourself at risk.

6. DISTRESSED OR AGGRESSIVE

If a client is becoming distressed or aggressive in an area where other community members are waiting or attending a group or could be put at risk at some point:

- Have a designated team member take the leadership role to coordinate any necessary actions including:
    - At least one worker will try to de-escalate the situation as well as encourage the client to move to a more private area to minimize risk to others in the vicinity.
    - At least one other worker will ensure that the persons witnessing any crisis escalation and de-escalation are as safe as possible and will debrief with these persons when deemed necessary.
- If it is deemed impossible to remove the client from the area without escalating the situation staff will make every attempt to safely escort the community members from the vicinity.
- If it is deemed impossible to safely escort community members from the vicinity staff will do their best to secure the area and maintain a safe environment while the situation exists.
- Write up an incident report (and suicide or crisis alert form if necessary) as soon as possible to ensure accurate reporting of the facts.

For situations where a team member must LEAVE the Health Center to attend to a potential crisis:

- Get as much information in advance of leaving the building so that a good assessment and plan of action for the potential crisis can be made before the visit including any history of violence, drug and/or alcohol usage, weapons in the house, etc.
- If a team member is contacted by a community member for a meeting, and if the client has a history of violence, this meeting must take place at the Health Center or with the appropriate back-up in place. i.e. DO NOT go alone if it is deemed unsafe: call in the appropriate resources and/or bring a co-worker with you.
- Inform the reception worker and anyone else deemed appropriate of where you are going and as precisely as possible, what the situation is.
- Identify yourself and do not enter without being invited in.
- Observe the state of the house. Assure your safety by having a clear exit way out. Stay out of living areas that may compromise your safety.
- Respect the other person(s) boundaries and private household areas.

- Staff should carry the Health Center cell phone and make arrangements before leaving with reception if they need someone to check in with them (especially in cases where staff do not go with back up). Make sure the cell phone unit is signed out with the unit # and name written down for reception to know which unit the staff member can be reached out.
- Call the Health Center as soon as the situation is under control or for any new developments. Try to end the visit on a positive note.
- Debrief as soon as possible.
- Write up an incident report (and suicide or crisis alert form if necessary) as soon as possible to ensure accurate reporting of the facts.

IN GENERAL

1. The office door should remain unlocked when you are working in your office so that we can have quick access in the event of an emergency.

2. Each team member should examine his or her office set-up, what items are lying around, etc. and modify where necessary to minimize danger to team members and community members in the event of a crisis situation.

3. Staff all have a responsibility to check out if a co-worker needs assistance with an aggressive or distressed client, including helping to avoid/minimize an assault on a co-worker.

4. It is imperative that staff support each other in these situations by utilizing the skills and experience that they have.

5. If someone is out of control and starts to destroy property, staff should not worry about saving building or equipment costs—personal safety is more important—staff should leave the area and call for back up from the appropriate resources. Staff should use the panic button if they have access to one without putting themselves at risk.

6. Write up an incident report (and suicide or crisis alert form if necessary) as soon as possible to ensure accurate reporting of the facts. A copy of the incident report may need to be given to the Sureté, if police response has been required.

7. No worker will be fired for using necessary self-defence.

8. All workers should be certified in emergency first aid and be prepared to administer aid whenever necessary.

9. Staff will call for back up to the appropriate resources for any situation staff cannot safely de-escalate on our own. If the situation requires the assistance of the Sureté staff will use the panic button if they have access to one without putting themselves at risk. Staff will follow the procedure for panic buttons as written above.

10. Staff will ensure that any persons in the building who have witnessed a crisis will be provided with support.

11. Staff have all signed an oath of confidentiality. This permits staff to share information with co-workers, therefore, staff should never hesitate to inform co-workers of a potential crisis situation with a client or family. If there is any risk for someone to harm themselves or others, confidentiality is waived.

12. Each person has a personal responsibility to make sure that they will debrief for any direct or indirect involvement in a crisis situation.

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INCIDENT AND ACCIDENT REPORTING

1. POLICY

All incidents and accidents must be reported and investigated to reduce the likelihood of recurrence. The medical, clinical staff and/or health center employee, contractual worker, student, volunteer or community member witnessing, discovering or involved in an incident or accident is responsible for completing the Incident /Accident Report form AH-223.

2. RATIONALE

The identification and documentation of incidents and accidents is essential to risk management. For every accident with a serious consequence, there are hundreds of accidents with minor or no consequences and many more incidents such as risk situations or near misses.

Anyone can be involved in an incident or accident given circumstances out of their control. The importance is that corrective or preventative action is taken.

The completion of an accident report must not compromise the person reporting, nor is it to be used for accusatory purposes. Rather, declarations permit a thoughtful analysis of the situations and are used to improve processes in order to avoid a repeat of a similar situation (no blame culture).

3. OBJECTIVES

The objectives for this policy are:

- To provide a common understanding of incidents, accidents and adverse events
- To define roles and responsibilities for the reporting of incidents and accidents.
- To explain the processes to be followed for reporting.

4. REASONS FOR REPORTING

- To ensure the reporting of an event, and provide appropriate summary analysis of reported events
- To clearly document the actions taken to control or limit consequences and to make pertinent comments to prevent a similar recurrence
- To transmit information to the manager responsible to ensure corrective and preventive actions occur.

5. DEFINITIONS

5.1 Accident

An action or situation where a risk event occurs which has or could have consequences for the state of health or welfare of the user, a staff member, a professional or a third person. Accidents include events that cause immediate consequences. These can be temporary consequences ranging from the need for monitoring, first aid, specialized care, and admission to hospital to permanent consequences such as the loss of function or death.

5.2 Incident

An action or situation that does not have consequences for the state of health or welfare of a user, an employee, a professional or a third person, but the outcome of which is unusual and could have had consequences under different circumstances. Incidents include risk situations, near misses and events that reach the patient but do not cause consequences.

5.3 Consequence

An outcome that negatively affects an individual's health and/or quality of life.

5.4 Event

A generic term used for any dangerous or undesirable situation, regardless if it is an incident or an accident.

5.5 Sentinel Event

Incidents or accidents which did or could have had catastrophic consequences. Incidents or accidents, which have occurred at a high frequency, even though there are no severe consequences.

5.6 Disclosure

Disclosure means that the Health Center will inform the user of all the information regarding an accident whereby they are the victim, the measures taken to counter the consequences and the measures taken to prevent recurrence.

5.7 Integrated Quality Safety and Risk Management Committee

All incident, accident and disclosure reports are reviewed periodically by the Integrated Quality and Risk Management, with recommendations to the Executive Director.

6. PROCEDURES FOR INCIDENTS/ACCIDENTS WITH CLIENTS

1. The priority for an incident or accident is to attend to the patient and ensure that the patient and the environment are safe, e.g. If there is a fall on a wet floor, you need to attend the patient and place a sign to inform of the wet floor.

2. Incidents or accidents are to be declared as soon as possible by the person at the origin of the event, a direct witness or who discovers or is first informed of the event. Complete the Accident Form and be sure to include:
    - If the report is regarding a user, indicate what type of user, e.g. (Home Care HC), (Outpatient OPD)
    - Give the time of the accident.
    - Indicate exactly where the event took place, e.g. a fall took place in the bathroom, beside the examining table, in the hallway, etc.
    - All reports need to be legible for the committee

3. Exceptions to the use of the form include undesirable events inherent to the clinical condition or treatment (Adverse Events), nosocomial infections and work accidents.

4. State facts accurately and concisely. Do not include assumptions, speculations or accusations about responsibility for the incident/accident.

5. Incident and Accident reports are always made in the name of the victim, e.g. the client who was hit by another client. The event is documented in the medical file of the client who was the aggressor. Two reports are required if both clients were injured.

6. The declarer is encouraged to make comments on how to prevent a recurrence.

7. For an event that resulted or could have resulted in grave consequences, e.g. a fracture, a flood; consider whether the event is sentinel. If so, communicate with the Manager who may refer to the Executive Director.

8. The Incident/Accident report is distributed as follows:
    - The Executive Director will be informed of the incident or accident by email **immediately** following the incident.
    - The white copy is placed in the patient's chart; if in the case of a non-patient incident, white copy remains with the Manager responsible for that department.
    - The yellow copy is submitted to the Executive Assistant and Administration Manager within 48 hours who will place the form in the Incident/Accident Report file.
    - The Integrated Quality Safety and Risk Management Committee will review the current Incident/Accident Reports from this file at the next meeting.

9. A Disclosure of Adverse Events is required for events that involve patient monitoring and follow-up. The process for Disclosure is described in the Disclosure of Adverse Events Process Policy.

10. For events whose origin is another health establishment, e.g. Laboratory St-Eustache, complete the form AH-223 and provide copies as indicated:
    - The Executive Director will be informed of the event by email **immediately** following the discovery.
    - The white copy is placed in the patient's chart.
    - A copy of the form is made and submitted to the Executive Assistant and Administration Manager within 48 hours who will place the form in the Incident/Accident Report file.
    - The yellow copy is forwarded to the Risk Manager or concerned Administrator of that institution.
    - The Integrated Quality Safety and Risk Management Committee will review the current report from the Incident/Accident Report File at the next meeting.

11. Reports pertaining to accidents, which are kept by the Executive Assistant and Administration Manager, are confidential.

12. Completed Accident forms are given to the manager responsible for follow-up of the event, who transfers the Report to the Executive Assistant and Administration Manager.

13. The Integrated Quality Safety and Risk Management Committee reviews all incidents and accidents and make recommendations to the Executive Director for corrective measures.

14. The Executive Director provides a summary report to the Board every 3 months.

7. PROCEDURES FOR STAFF ACCIDENTS

All work place accidents must be reported using the same AH-223 Form. Managers must analyze all work place accidents in their area and report findings using AH-223 Form 2.

1. Staff are to complete the AH-223 form when an accident occurs, e.g. scratched by a client, back strain while transferring, verbal abuse, needle stick injury, burn, cut, etc.

2. AH-223 form is completed in the name of the staff member who has suffered consequences. These forms are not meant to document or track a client behavior; the client chart is used for this purpose.

3. In situations where a staff does not suffer consequences but identified a risk situation or a near-miss, e.g. defective equipment, faulty gloves, lack of isolation gowns, etc., details are to be provided on the AH-223 form.

4. The AH-223 is given to the Executive Assistant and Administration Manager who refers it to the Executive Director. The form is kept in the Incident/Accident Report file.

5. The Executive Director mandates the appropriate Manager to conduct an analysis of the event using the Accident Analysis Form (AH-223-2). The follow-up of any corrective or preventive measures is the responsibility of the Manager of the area where these measures must be taken. The Executive Director may delegate a person to ensure corrective measures were achieved.

6. When the analysis is completed by the Manager, it is sent to the Executive Director who will ensure the necessary follow-up. The analysis report is added to the Accident Report in the Incident/Accident Report File.

7. A yearly statistical report is provided to the Board of Directors. (graph)

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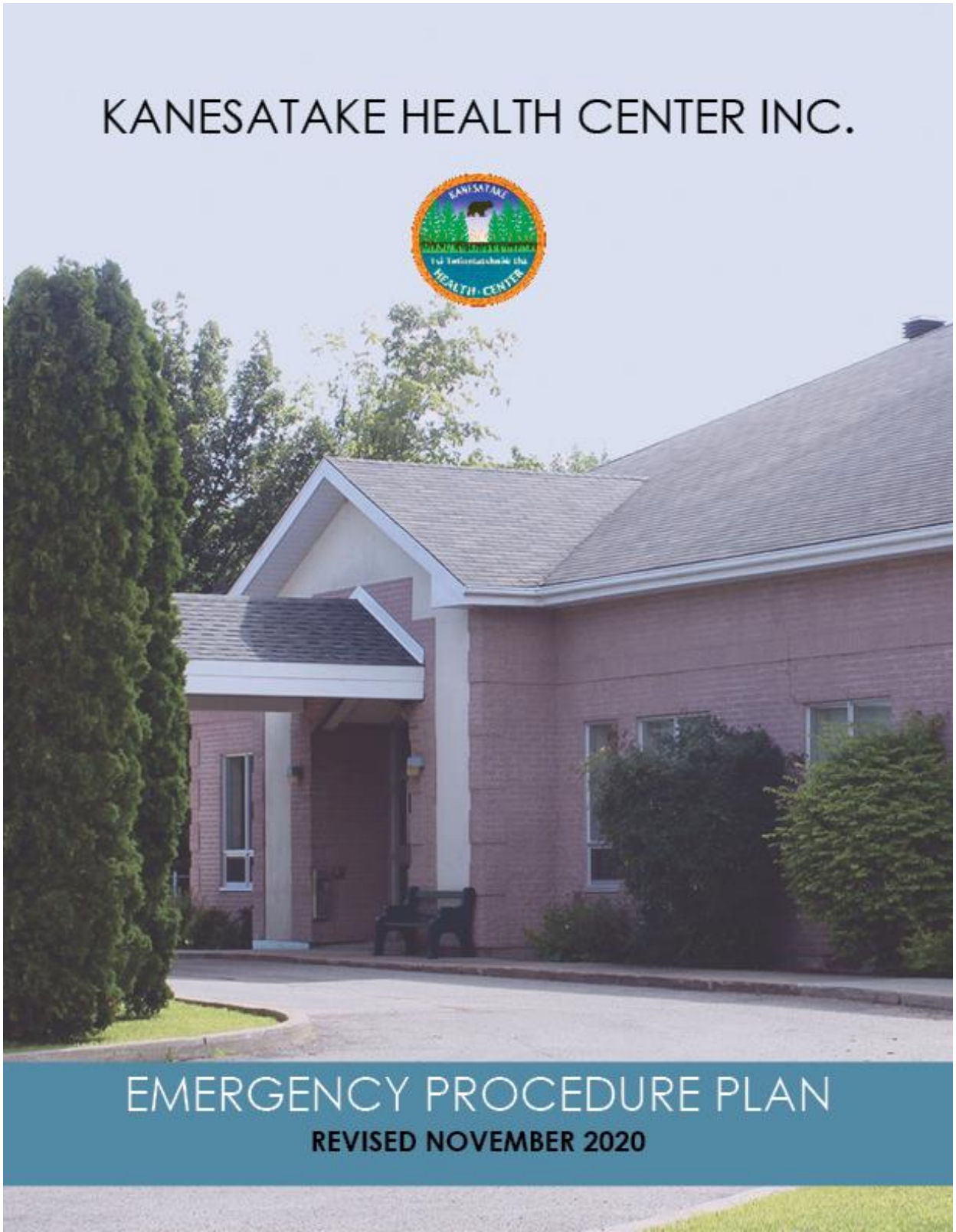

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Introduction

This Emergency Procedure Plan outlines the steps to follow for all employees and clients of the Kanesatake Health Center Inc. in the event of an emergency situation or evacuation. The Kanesatake Health Center's Emergency Procedure Plan is aligned with the plan of the **Kanesatake Emergency Preparedness Plan**.

The objective of the Emergency Procedure Plan is to ensure the safety of all employees and clients, as well as all visitors to the Kanesatake Health Center Inc. The plan will be used to prevent accidents, fatalities and injuries; to reduce harm to individuals directly or indirectly involved as well as damage caused to the building and its contents; to ensure the continuity of essential services and to facilitate a return to normal activities as soon as possible.

All employees must be aware of their responsibilities and tasks that they must carry out in the event of unexpected emergency situations.

Organization and Responsibilities:

Business name:	Kanesatake Health Center Inc.
Address:	12 Joseph Swan Kanesatake, Québec, Canada J0N 1E0
Property:	Health Canada
Executive Director:	Ms. Joyce Bonspiel Nelson Home: (450) 479-8588 Cell: (514) 726-8588
Executive Assistant & Administration Manager:	Ms. Shirrillean Nelson Home: (450) 479-8795
Custodian:	Ms. Peggy Jacobs Home: (450) 479-6241

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Janitor: Mr. Christopher Meloche
Home: (438) 822-1564

Number of Employees:

Week days: 33 employees **Weekends**: None in the building
Week nights: (6:00 pm to 10:00 pm) Tues & Thurs evenings, Anger Management worker and clients.

Description of the Building

Construction:

Structure	Brick and wood
Construction date	1996
Number of floors	1 floor no basement
Exterior finish	Brick
Interior finish	Strapping and drywall
Original Building	Built in 1996
New building extension	Built in 2009
Exits / Emergency doors	4 exits

Heating system:

Electricity	All through the building
Auxiliary Power	Kohler, model 180RE0ZIC Diesel Generator

Emergency Systems:

Connected to Alarm Company	Jean-Paul Bigras INC. (450) 472-3725) Central for alarm (514) 323-3974
Portable fire extinguishers	Pyrosecur-Prevention Incendie (514) 992-7976)
Emergency power generator	Generatrice Drummond 1(800) 567-335)
Employee telephone fan-out system	
Video surveillance system	

List of Fire Security Material:

The building is not equipped with a sprinkler system, there is emergency lighting system at all exits of building. In the event of a power outage the building is fully operational due to the generator.

Fire Protection:

- Alarm system: Edwards (relayed)
- 2 hose cabinets with 1inch hose lines
- 8 fire extinguishers

There are eight (8) fire extinguishers available:

- Front main entrance
- Front hallway
- Front middle hallway
- Mechanical room
- Front side door
- Staff kitchen
- Back hallway
- Back side entrance

*** See appendix 3 for K.H.C building plan**

Pull-Stations:

The pull-stations are used to manually trigger an alert for fire. They are activated by pulling down on the lever until the glass breaks.

There are Four (4) pull-stations located at the entrances:

- Front Door
- Front side door (near the Doctor's office)
- Back side door
- Kitchen

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*** See appendix 3 for K.H.C building plan**

Types of Potential Emergencies:

Possible Hazard	Likelihood	Vulnerability
Fire	Moderate	No aqueducts and fire hydrant in the area
Explosion (Generator)	Low	
Pandemic	Low	
Civil Disorder	Low	School and Mohawk Council buildings close by
Earthquake	Low	
Flood	Low	
Hazardous Materials	Low	Presence of bio-hazard substances in the building
Winter Storm / Ice Storm	Moderate	

** The Kanesatake Health Center's Emergency Procedure Plan is aligned with the plan of the Mohawk Council of Kanesatake* ***Emergency Preparedness Plan****.*

Roles & Responsibilities

- **Executive Director:**
  - Business continuity plan identifies the critical services that must be continued during and following a disaster or emergency, and outlines how the organization will manage services during this time. The KHC is also a possible staging area for the M.C.K and their Emergency Preparedness Plan.
  - linkages to the Community Emergency Coordinator

- **Executive Assistant & Administration Manager (Emergency Coordinator):**
  - Regular testing of at least one type of emergency annually.
  - Uses results of drills to review and revise the emergency plan as necessary.

- **Triage Coordinator - Nurse Manager**

- Field triage- sorting clients/personnel into those who need critical attention and immediate medical attention and those with less serious injuries;
- Links with local emergency medical services and/or hospitals;
- The use of altered care standards (e.g., when demand for care provided in accordance with current standards exceeds resources), including conditions under which altered care standards are activated, how emergency responders will be notified of the activation, and how to apply altered care standards in the field;
- having a back-up supply of medication, dressings, masks etc.

- **Nursing staff** first aid, life support etc.)
- **Clinical non-nursing Staff** (psychological support, debriefing etc)
- **Support staff** (directing traffic, stand-by for transport etc.)
- **Communications**:
  - Essential information and messages that must be sent and received, to whom they should be communicated (i.e. staff, clients, community, police etc.) , and how the organization will send communications internally and externally.
  - Back-up plan for server failure.
  - Press conferences

- **Receptionists**:
  - Make sure the staff and emergency contact list is up to date;
  - Make sure to bring the attendance book (sign in/out) upon evacuation;
  - Make sure that the replacement secretary is aware of the procedures;
  - When the emergency procedure is started, the secretary advises the following people:
    - **911 state your emergency**

- **Executive Director, and/or Executive Assistant & Administration Manager**
- **Building Custodian and/or Janitor**

- **Employees Role:**
  - On a daily basis, report any abnormality to the appropriate person in charge and/or manager;
  - On a daily basis: ensure hallways and all exit doors are clear of obstructions preventing evacuation;
  - Be knowledgeable about the Fire Evacuation Plan;
  - Know the locations of the pull stations, exits and extinguishers, the safe zones and the relocation sites;
  - Adhere to the Fire Evacuation Plan.

Emergency Calling Chain List:

In order to quickly contact the employees who are not at work at the time of the emergency, and that are expected to arrive to work, a calling chain list is included as a back-up plan. The calling chain is activated using the following procedure:

- During working hours, the **Executive Director,** Joyce Bonspiel-Nelson, and or designate will activate the calling chain list;
- After regular hours the alarm company contacts the custodian or designate who then informs the Executive Director:
  Margaret Peggy Jacobs, Custodian (450) 479- 6241
  Christopher Meloche, Custodian (438) 822-1564

*** See appendix 2 for K.H.C Calling Chain List**

Employees & Clients:

Employees and clients must be conscious when moving their vehicles to park as far away as possible from the fire and designated safe zone and not interfere with the emergency vehicles. This will permit for quick evacuation of employees and cliental.

All employees arriving back to work at the K.H.C must report and identify themselves to the person-in-charge, indicated by a vest with reflection, who in turn will record their names.

Evacuation:

Evacuation to a safe location will take place when authorized by the Fire Department, Police Department or designate.

Fire Alarm Report:

This report should be filled in by the Fire Department Coordinator immediately following a fire or fire drill once everyone is in a safe location. (see appendix 1)

Outside Emergency Organizations:

All Emergencies (Fire, Police, Ambulance)	9-1-1
Oka Fire Department	(450) 479- 8333
Sureté du Québec	(450) 479-1313
Jean-Paul Bigras INC. Alarm Company Video surveillance system Central for activated alarm (code needed)	(450) 472-3725 (514) 323-3974
Pyrosecur-Prevention Incendie (Portable fire extinguishers)	(514) 992-7976
Generatrice Drummond (service reference # T-S-7283)	(1800) 567-3835
Petrol Belisle Fuel Storage Tank	(450) 473-9212
Stericycle Inc (Bio Medical Waste Pickup)	(450) 635-3311

Temporary Shelter (Ratihente High School Gym located at 681A Ste-Philomene)

Pharmacy: 1st contact (Josiane Kachami) (450) 479-8448
2nd contact (Marc-Andre Joly)
3rd. contact (Antoine Belanger

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M.C.K Emergency preparedness: Chief Patricia Meilleur (450) 479-8373

General Directives:

In case of a fire or emergency, dial 911

- Stay calm;
- Dial 911
- Advise the staff;
- Keep doors shut especially where the fire was declared;
- Calmly escort all clients and visitors out of the building and secure them in the safe zone;
- Do not attempt to get your personal belongings;
- Follow the directives of the person in charge.

Directives when the alarm goes on:

- Make a quick tour to locate the fire, if necessary;
- If it's a false alarm, try to get the alarm to stop ringing; re-enter your alarm code, press disarm or call central at (514) 323-3974
- Be prepared for the central (Alarm Company) to call.
- Failure to reach someone, the central (Alarm Company) will immediately send the firefighters to the Health Center.

Directives for the person who discovers the fire:

- Take a portable fire extinguisher;
- Ensure the path is free to go out;
- Fight fire with fire extinguisher only if the flames are less than one meter in height, spray at the base of the fire;
- If possible, be accompanied by another person;
- Evacuate occupants from the inflamed rooms;
- Close doors and windows behind you.

Gathering places for evacuation:

- Depending on the emergency, the gathering point is situated in the drive way across the street at Kanesatake Human Resources Office (KHRO) at 14 Joseph Swan, Kanesatake.

At the gathering point (safe zone) everyone must:

- Follow the directives given from the Coordinator or Emergency Personnel;
- Remain calm;
- Stay away from the building and remain within the group;
- Wait for instructions before regaining the building or leaving the scene.

K.H.C Emergency Procedure Plan

One of the purpose of the Emergency Procedure Plan is to reduce the risk of fires and / or emergencies through prevention.

Prevention is:

- Good housekeeping practices;
- Good maintenance practices;
- Good employee discipline;

Human Resources Responsibilities:

- Ensure that all employees have received and signed off on receipt of the Emergency Procedure Plan;
- Ensure that all employees are knowledgeable of the basic fire hazards in the workplace and are given annual training through fire drills.

Employees Role:

- General knowledge of procedure;
- Know who the designated coordinator is;
- Know where to find a fire extinguisher, the alarm pull station and emergency exits;
- Know the gathering point (KHRO parking lot);

- Respect the directives given by the Executive Director, the Coordinator and the Emergency Team.

EVACUATION REPORT

Préventionniste/Coordinator : _____

Event: Fire Drill

Date: _____/_____/_____ Time: _____:_____

Evacuation time _____:_____

Presence of emergency services: ☐ Yes ☐ No

Which service? _____

Number of persons in the building prior evacuation: _____

☐ Total evacuation ☐ Partial evacuation

Observation:

_____

_____

Recommendation:

_____

_____

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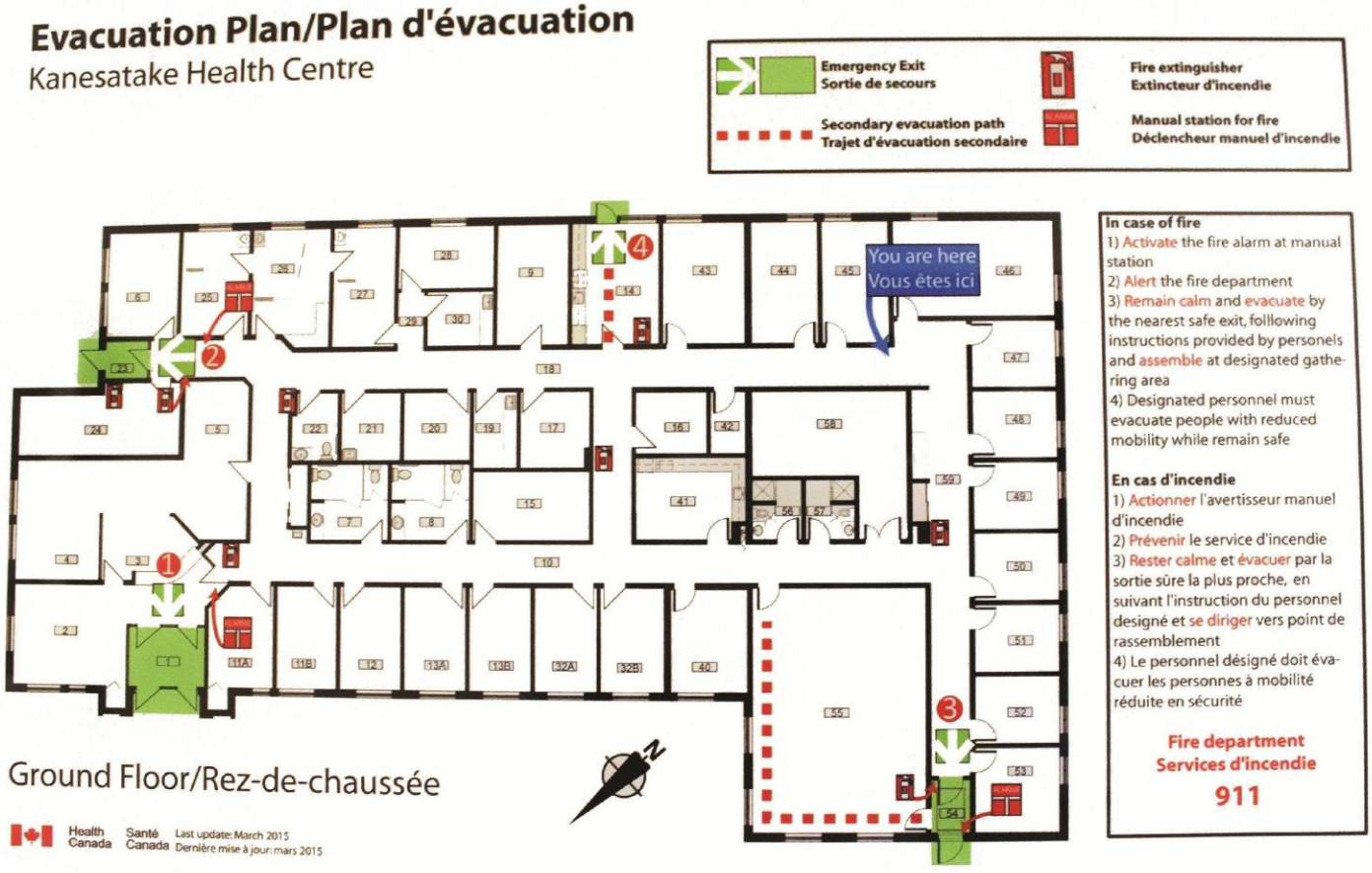

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VACCINATION POLICY

1. POLICY

As per the mandate from the Provincial Public Health Authorities, all Health and Social Services workers whether they are in close direct contact with patients or not, must be adequately vaccinated against covid-19, unless they have medical reasons and provide proof of such.

2. PROCEDURE

All staff members are required to provide proof that they are fully vaccinated (two doses). Staff members will provide a copy of the vaccination proof to the Human Resource and Accreditation Coordinator, who will then place the document in their personnel file.

Staff members who cannot receive vaccination for medical reasons must provide proof of such to the Human Resource and Accreditation Coordinator, who will place the document in their personnel file.

3. FAILURE TO COMPLY

Without such proof, staff members will not be allowed to return to work and will receive no compensation nor benefits.

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WORKPLACE HEALTH AND SAFETY

The Kanesatake Health Center Inc. management promotes a healthy work environment to value its employees. This is done in two ways:

- By supporting their overall mental, emotional, physical and spiritual well-being;
- By ensuring that the health, dedication, attributes, talents and skills employees bring to the workplace are recognized and encouraged.

1. INTEGRATED QUALITY SAFETY RISK MANAGEMENT COMMITTEE

The Integrated Quality Safety Risk Management Committee has the responsibility to oversee health and safety issues in the workplace, and to advise the Executive Director on ways to address issues of risk as they arise. In addition to quality improvement, the work of the committee is to look at health and safety issues in the work environment, to review incident and accident reports, and to make recommendations for corrective actions.

The Membership of the Integrated Quality Safety and Risk Management Committee includes:

- Executive Director
- Manager of Nursing Services
- Executive Assistant and Administration Manager
- In-Home Support Manager
- Child and Family Support Manager
- Representative of Riverside elders Home
- Human Resources and Accreditation Coordinator

2. INCIDENT REPORTING

All staff are required to complete incident and accident reports as per policy, as well as reporting adverse events, near misses and sentinel events.

Any staff member who has an issue with regards to health and safety within the workplace can address the matter with a member of the Health and Safety Management Committee.

3. FIRST AID

All employees must have basic training in First Aid and CPR so that they can be of assistance in any type of emergency. It is also mandatory for all Frontline employees to take a refresher course in CPR every year.

4. INTENT TO DO HARM

There is zero tolerance for any explicit or implicit expression of intent to do harm, or any inappropriate communication on the premises of the Kanesatake Health Center or at any external sites where there are activities managed by Health Center staff.

- An inappropriate communication contains ominous, unsettling, or questionable language or suspicious activities.
- All threats are inappropriate but not all inappropriate communications are threats.

1. There will be clarification sought for any implicit or explicit expression of intent to do harm that has been brought to the attention of the staff member.
    a. The clarification is made by asking the person: “Is that a threat?”
    b. Staff will assess the level of risk (low-medium-high) to the potential victim(s) during this clarification process.
    c. Staff will assess the value of the threat (intent, motive and ability).

2. The person(s) making the threat(s) will be clearly told of the process staff will take, which is immediate notification of threat to the police.

3. An Incident Report Form must be completed by the employee and submitted to his/her Manager who then would refer the Incident to the Executive Director.

Nevertheless, there may be crisis situations in which staff members must intervene as part of the services provided by the Center. To this end, staff members will intervene in a way that positively influences the resolution of the immediate crisis.

5. FALL PREVENTION

Adopting a culture of fall prevention at the Kanesatake Health Center is the responsibility of all personnel. This includes, among other items:

- promoting safe fall prevention practices at all times;
- opening doors for elderly and/or physically/visually limited persons;
- offering help to walk people through the Health Centre;

- reporting and/ or immediately correcting a fall-risk situation (water on floor, broken equipment etc.);
- completing an incident report (see Appendix 1) when a near fall or a (reported and/or observed) fall has occurred. Once completed, the incident report form is given to the immediate superior, then forwarded for review by the Integrated Health, Safety & Risk Management committee, whereupon measures will be implemented to lessen the reoccurrences of falls or near-falls.

Home Visits: Staff members who conduct home visits are obligated to take the Falls prevention training.

6. FIRE SAFETY

A regular inspection of the health facilities is conducted by a federal fire inspector to ensure that the building remains in conformity with federal fire codes. Recommendations following such an inspection is discussed with the Workplace Health and Safety Committee.

A fire drill is practiced at least once a year during regular hours so that the staff can practice following the appropriate procedures with clients present.

7. EMERGENCY PROCEDURE

All employee must:

- Have general knowledge of emergency procedure plan;
- Know who the designed coordinator is;
- Know the location of the fire extinguishers, the alarm pull station and emergency exits;
- Know the gathering point;
- Respect the directives given by the Executive Director, the coordinator and the emergency team.

8. SMOKE FREE ENVIRONMENT

Kanasetake Health Center is committed to the health and safety of our employees and everyone visiting our premises. Therefore, smoking and vaping is prohibited throughout all indoor facilities.

This policy applies to all employees, visitors and clients.