Accommodating Workers with Disabilities

ST. JOSEPH'S CARE GROUP

POLICY Number: **HR 7-30**

Manual:	Global Human Resources Manual	**Approval Date:**	February 21, 2023
Section in Manual:	Human Resources	**Approved by:**	Human Resources Quality Committee

Cross References: *AD 01-150, AD 01-160, HR 07-044*

Preamble

When a worker is unable to perform their regular job due to a temporary or permanent disability, the employer has an obligation to determine if reasonable accommodation is available to the worker. The objective of this policy is to support a work environment that is inclusive, without discrimination and to establish effective mechanisms for responding to the individual accommodation needs of existing and potential employees.

Definitions

The term disability covers a broad range and degree of conditions, some visible and some not visible. A disability may have been present from birth, caused by an accident, or developed over time. There are physical, mental and learning disabilities, mental disorders, hearing or vision disabilities, epilepsy, mental health disabilities and addictions, environmental sensitivities, and other conditions.

"Disability" includes:

a) Any degree of physical disability, infirmity, malformation or disfigurement that is caused by bodily injury, birth defect or illness and without limiting the generality of the foregoing, includes diabetes mellitus, epilepsy, a brain tumor, any degree

of paralysis amputation, lack of physical coordination, blindness or visual impediment, deafness or hearing impediment, muteness or speech impediment, or physical reliance on a guide dog or other animal or on a wheelchair or other remedial appliance or device.

b) A condition of mental impairment or a developmental disability,

c) A learning disability, or a dysfunction in one or more of the processes involved in understanding or using symbols or spoken language,

d) A mental disorder, or

e) An injury or disability for which benefits were claimed or received under the insurance plan established under the Workplace Safety and Insurance Act, 1997.

Barrier

A barrier is anything that prevents a person with a disability from fully participating in all aspects of society because of his or her disability, including a physical barrier, an architectural barrier, an information or communications barrier, an attitudinal barrier, a technological barrier, a policy or practice.

Worker

This policy is applies to employees and prospective employees and does not apply to volunteers and/or other non-paid individuals.

Accommodation

Accommodation is understood as any temporary or permanent measure used to remove barriers which prevents an otherwise qualified individual from performing or fulfilling the essential duties of a job.

Policy Statement

1. St. Joseph's Care Group recognizes the diversity of its workforce and is committed to ensuring that all workers are able to effectively and efficiently

use their skills and experience to contribute to the organization's performance, production and service delivery. SJCG establishes and maintains an effective system to ensure an inclusive workplace and provide suitable and available workplace accommodation.

2. SJCG responds in a timely, confidential and sensitive manner to requests for individual accommodation in the workplace.
3. Individualized accommodation plans take into consideration accessibility issues as outlined in the Accessibility for Ontarians with Disabilities Act. SJCG is committed to the reduction of barriers and the improvement of accessibility on an ongoing basis.
4. Accommodations are designed cooperatively with the worker, in consideration of the principles of inclusivity, respect for dignity, individualization, and integration and full participation.
5. SJCG's accommodation processes are in accordance with the Ontario Human Rights Code.

Procedure

When an employee is unable to perform their regular job due to a permanent illness/disability, or discloses a disability upon hire, the employer may have an obligation to accommodate that employee.

1. Accommodation can be:
    i. Requested by the employee by completing the Accommodation Request for Medical Reasons Form (see Appendix A)
    ii. Identified by the employee's manager or hiring manager
2. Gather relevant information and assess individual needs. The employee is an active participant in this step
    i. Information will be collected on the employee's functional abilities, not the nature of the employee's disability
    ii. The employee's medical information, is uploaded to their electronic medical record and is confidential. It will only

be disclosed to individuals who need it to perform the accommodation process.

3. The employee and their manager will work together to find the most appropriate accommodation.

   A medical practitioner or other health care expert (e.g. specialist) may be engaged (at the company's expense) to help determine if/how the employee's needs can be accommodated.

   The employee may choose to include their respective bargaining agent or other workplace representative to participate in the process.

4. Write an Individual Plan

After identifying the most appropriate accommodation, and document the details in the Accommodation Plan Form (See Appendix B), including

i. The nature of the accommodation(s) that will be provided in an individualized accommodation plan

ii. The nature of an individualized Workplace Emergency Response Plan (if necessary) developed by the manager and the employee (See Appendix C)

iii. Employee emergency information and/or emergency response plan (if applicable)

iv. How to make information accessible to the employee, including accessible formats and communication supports

v. When the plan will be reviewed and updated

The manager will provide the employee a copy of the individual accommodation plan (in an accessible format), or written reasons for denying accommodation

5. Implement, Monitor and update the Plan

   i. After implementing the accommodation plan, the employee and their manager will monitor and review the plan to ensure that it is effective. Formal review and updates will take place on the mutually agreed upon, predetermined schedule in the employee's

accommodation plan. If the accommodation is no longer appropriate, the employee and the manager will reassess the situation (step 2) and update the plan.

Where needed, we will also provide customized emergency information to help an employee with a disability during an emergency. With the employee's consent, we will provide workplace emergency information to a designated person who is providing assistance to that employee during an emergency.

We will provide the information as soon as practicable after we become aware of the need for accommodation due to the employee's disability.

We will review the individualized workplace emergency response information:

a) When the employee moves to a different location in the organization;

b) When the employee's overall accommodations needs or plans are reviewed; and

c) When the employer reviews its general emergency response policies.

References

Ontario Human Rights Code RSO 1990 or as amended

Workplace Safety and Insurance Act, 1997 or as amended

APPENDIX A

ST. JOSEPH'S CARE GROUP

Care Compassion Commitment

Occupational Health, Safety & Wellness
35 Algoma St N, Thunder Bay, ON P7B 5G7
Phone (807) 343-2427 Fax (807) 346-2353

Accommodation Request for Medical Reasons

Section A: Employee Information *(to be completed by employee)*

Name: _____ PrimaryPhone #: _____

Address: _____ City: _____ Postal Code: _____

Email Address: _____

Site: _____ Department: _____ Job Title: _____

LAST DAY WORKED: _____ FIRST MISSED SHIFT: _____

Section B: Consent (to be completed by the employee)

I authorize the physician to complete the Accommodation Request for Medical Reasons based on my current medical condition to provide Occupational Health, Safety & Wellness medical information strictly for the purposes of managing my illness/injury.

I consent to allow Occupational Health, Safety & Wellness to provide information related to my fitness for work and accommodation needs to my Manager/Supervisor, Human Resources, Union and other who may be involved with my Return to Work process. *Medical information will remain confidential.*

I agree to the release of information.

Print Employee Name	Employee Signature	Date
Print Witness Name	Witness Signature	Date

St. Joseph's Hospital
Corporate Office
35 Algoma St. N.
Thunder Bay, ON P7B 5G7
(807) 343-2431 • sjcg.net

Balmoral Centre
(807) 623-6515

Hogarth Riverview Manor
(807) 625-1110

Sister Leila Greco Apartments
(807) 625-1126

Sister Margaret Smith Centre
(807) 684-5100

St. Joseph's Health Centre
(807) 624-3400

St. Joseph's Heritage
(807) 768-4400

Section C: ***Physician to complete the following in detail***

Disability and related medical diagnosis:

Physical:_____

_____

_____

Psychological:_____

_____

_____

Does this disability require accommodation to normal work duties?

□ Yes □ No

Duration of Restrictions:

□ Temporary(time frame)_____

□ Permanent:_____

□ Treatment Plan:_____

□ Date of next assessment:_____

If accommodation is required, please complete the functional abilities form attached to identify <u>specific restrictions</u> as it relates to the worker's position.

By affixing my signature below, I certify that I am a qualified medical health professional and that I have personally assessed and treated the above patient/employee. It is my opinion that the information is true and accurate.

NOTE: Forms will not be processed for payment unless completed in full

Practitioner's Name (Please Print):_____

Address:_____ Telephone:_____

_____ _____

Signature Date

Once completed please return by confidential fax or mail to Occupational Health, Safety & Wellness
Fax # (807) 346-2353
St. Joseph's Care Group, 35 Algoma St. N., Thunder Bay, ON P7B 5G7

APPENDIX B

SAVE

PRINT

St. Joseph's Care Group
Occupational Health, Safety & Wellness
35 Algoma St N. Thunder Bay, ON P7B 5G7
Phone: (807) 343-2427 Fax: (807) 346-2353

Accommodation Plan

Employee Name: _____ Date: _____

☐ Temporary Accommodation ☐ Initial Meeting Department: _____

☐ Permanent Accommodation ☐ Follow-up Meeting Job Class: _____

☐ Waiting for Placement ☐ Placement Meeting Status: Full Time Permanent

Union: Non Union Site: _____

Last Day Worked: _____ Program Start Date: _____

Program End Date: _____

Disability: ☐ Physical ☐ Mental

Restrictions:

Present Job Suitable: ☐ Yes ☐ No

Areas identified as suitable work:

Plan of Action:

Responsible Person:

Plan of Action:

Responsible Person:

Plan of Action:

Responsible Person:

Plan of Action:

Responsible Person:

Coding & department being charged
Manager to advise staffing of plan

Comments/Discussion:

EFAP – Card & Pamphlet provided: ☐ Yes ☐ No ☐ N/A

Next Meeting Date:

In Attendance

Employee:

Union Representative:

Manager/Designate:

Occupational Health:

Human Resources:

Other:

APPENDIX C

St. Joseph's Care Group
Thunder Bay ON

Employee Emergency Response Plan

All information in this document is confidential and will only be shared with the employee's consent.

Date: _____ Telephone: _____

Employee Name: _____

Department: _____

Work Location: _____

Emergency Alerts Employee will be informed of an emergency situation by:

Existing alarm system ☐ Pager Device ☐ Co-worker ☐

Visual alarm system ☐ Other (specify): _____

Assistance Methods List types of assistance (eg. Staff assistance, transfer, instructions, etc.)

Equipment Provided List any devices, where they are stored, and how to use them:

Evacuation Route and/or Procedure Provide a step-by-step description, beginning from the first sign of an emergency:

Alternate Evacuation Route

Emergency Support Staff The following people have been designated to help the employee in an emergency:

Name	Location and/or Contact Information	Type of Assistance

Consent to share individualized emergency response information.

I _____ consent to _____ sharing this individualized emergency
(employee) (organization)
response information with the individuals listed above, who have been designated to help me in an emergency.

_____ _____
Signature Date

Accommodation Requirement: Permanent ☐ Temporary ☐

Next Review Date: ☐

Form completed by:

_____ _____
Signature (Manager) Date

Form reviewed by:

_____ _____
Signature (Employee) Date

Copy to: Employee Health File
Human Resources File
Manager