

ONTARIO NURSES' ASSOCIATION

Submission to the Expert Advisory Panel to Review Ontario's Occupational Health and Safety System

June 28, 2010



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EXECUTIVE SUMMARY

Introduction

The Ontario Nurses' Association (ONA) is the union representing 55,000 front-line registered nurses and allied health professionals and more than 12,000 nursing student affiliates, providing care in Ontario hospitals, long-term care facilities, public health, the community, clinics and industry.

Statement of Beliefs: Occupational Health & Safety

The Ontario Nurses' Association believes that it is the right of all its members to work in a healthy and safe work environment. It further believes in the pursuit of the highest degree of physical, mental and social well-being of workers in all occupations. As one of the largest health care unions in the province and in the country, ONA believes it is part of its mandate to exercise a strong leadership role in achieving progressively greater gains in the field of occupational health and safety.

Work of Expert Panel

The health care sector contains some of the most complex working environments in the province, but has only relatively recently awakened to occupational health and safety. SARS was a health and safety consciousness-raising event for all workplace parties. Many were surprised by the late Justice Campbell when he wrote in his SARS Commission report, *Spring of Fear*:

Hospitals are dangerous workplaces, like mines and factories, yet they lack the basic safety culture and workplace safety systems that have become expected and accepted for many years in Ontario mines and factories...¹

This finding corroborated the 2005 observation of then Minister of Health and Long-Term Care (MOHLTC) George Smitherman, who said to an audience of nurses:

“One of the things I was struck by...[was] the number of nurses that work in environments, hospital environments more particularly, that actually are unsafe...We have a lot of work to do on that.”²

There is a lot at risk with occupational health and safety in health care. Evidence substantiates the linkages between occupational health and safety and patient safety.^{3,4,5} Justice Campbell noted in his report:

“In most workplaces, the primary role of occupational health and safety laws, regulations and systems is to protect workers. Health care settings are different. They are workplaces where occupational health and safety protections perform a double duty, safeguarding workers while also shielding patients and visitors... If workers are not protected from health and safety hazards, patients and the public are not protected either. It’s that simple.”⁶

Despite the serious stakes, i.e. worker and patient safety, Ontario’s health care employers are lagging far behind industrial health and safety leaders who have embraced occupational health and safety as a core value in their organizations. In 2001, U.S. Treasury Secretary and former corporate executive Paul O’Neill delivered a controversial speech about his experience in industry. He said:

“What’s needed is for ‘safety to be as automatic as breathing...It has to be something unconscious almost...Safety is not a priority at [his company], it is ...a precondition. If a hazard needs to be fixed, it’s understood by supervisors and employees that you do it today. You don’t budget for next year.” O’Neill told his financial people, *“If you ever try to calculate how much money we save in safety, you’re fired.”* Why? He didn’t want employees looking at safety as a “management scheme” to save money. *“Safety needs to be about a human value. Cost savings suggest something else. Safety is not about money; it’s about constantly reinforcing its value as... a precondition.”⁷*

Particularly because of the potential benefits for workers as well as patients and the public, ONA hopes that Ontario’s health care sector will embrace occupational health and safety as an

unconscious core value, as “automatic as breathing ...a precondition”. We wish that our members worked in an environment in which health and safety was second nature, and in which employers regularly exceeded minimum standards. Sadly, our reality, as confirmed by the SARS Commission report, is that the sector is lagging decades behind the rest of the workforce as we strive to simply reach the minimum health and safety standards. As such, Ontario’s health care sector is especially in need of aggressive measures to jumpstart a health and safety culture.

Since SARS, ONA has witnessed substantial occupational health and safety progress in the health care sector, but much remains to be done. The sector’s awakening to occupational health and safety has revealed system flaws which need to be remedied if we are ever to reach a point where occupational health and safety is an unconscious core value. We welcome this opportunity to share our insights and evidence and suggestions for change in Ontario’s occupational health and safety system.

In this submission, we address the issues raised by the Panel, provide evidence of our findings and rationale for our conclusions. The discussions and recommendations cover four main areas that could strengthen the internal responsibility system (IRS) and establish a culture of safety in health care. ONA believes the government needs to:

- Lead by example – e.g., the highest levels of the Ministry of Health and Long-Term Care (MOHLTC) must publicly commit to occupational health and safety law and principles and use a variety of tools to ensure top-down education and personal accountability in the ministry and throughout the sector.
- Broaden enforcement, consolidate preventive and reactive enforcement in the Ministry of Labour (MOL), and direct and empower inspectors to more easily enforce top-down accountability for occupational health and safety.
- Enact legislative amendments and enhancements to expand the powers of Joint Health and Safety Committees (JHSCs) and address reprisals.
- Establish and enforce training standards and broaden the reach of training from schools to regulatory colleges, and government and workplace leaders, supervisors, workers and JHSCs.

Throughout our submission, we offer recommendations which are summarized below:

Partners in the Occupational Health and Safety System Section

Recommendation:

1. Because for 13 years, the Workers' Safety and Insurance Board (WSIB) has:
 - failed to learn and apply occupational health and safety principles and law to its own operation with devastating effects on vulnerable, injured workers; staff have not been trained in occupational health and safety law and principles, nor the rules of evidence, and through their ignorance, decision-makers have actually made decisions which have contributed to reinjury and further injury of workers;
 - generated injury/illness statistics based on cost consideration, which do not accurately reflect occupational health and safety in workplaces, and upon which the MOL improperly bases enforcement activities;

ONA recommends that prevention responsibilities and activities be completely removed from the WSIB, and that the WSIB's inaccurate statistics not be used for any health and safety enforcement activities.

2. Given WSIB's continued influence over the safe return to work of injured workers, WSIB should train decision-makers in occupational health and safety law and principles (*reflected in draft 14 of the principles document – see Appendix A – Tab 4*) and the rules of evidence, and apply to decision-making, particularly with respect to safe return to work of vulnerable, injured workers.
3. Expand the MOL's role and similar to police agencies, charge it with enforcing law through reactive and preventive actions (*see more in "Enforcement" section*). Move prevention to the MOL so that reactive and preventive enforcement initiatives and programs:
 - a. can be developed with the common goal of achieving safe and healthy workplaces;
 - b. can be developed based on comprehensive qualitative and quantitative measures;
 - c. can consider injury data based on the reporting requirements of the *Occupational Health and Safety Act (OHSA)*, capturing lost-time injuries and "near misses."

4. In order to develop a more accurate picture of occupational health and safety, the MOL should develop its own database of injuries and “near misses” based on the reporting requirements of the *OHSA*. In the alternative, the MOL and WSIB should work together to revise the existing WSIB database to accurately reflect all workplace injuries regardless of cost and correct its practices, which currently allow employers to inaccurately report lost-time injuries as no lost-time injuries when the employer keeps the wages whole. Furthermore, employers in Ontario should have one business number assigned to them for all government purposes so that information can be cross checked.
5. Revise section 53 of the *OHSA* and related regulations to include requirements for reporting similar “near misses” in other workplaces. For instance, why is it only important for a *constructor* to report “a worker falling a distance of three metres or more,” or “a worker becoming unconscious for any reason?”
6. The MOL should use the revised database of injuries and other indicators, including inspections, to identify employers that could benefit from more extensive occupational health and safety audits, and order same.
7. The current Workwell audit function should be removed from the WSIB and transferred to the new prevention arm at the MOL. As one tool for prevention, MOL inspectors should be empowered to order them as a “precaution reasonable” under the general duties’ clause. The Workers’ Health and Safety Centre (WHSC), Occupational Disability Response Team (ODRT) and the Public Services Health and Safety Association (PSHSA) should support this function by assisting employers to improve health and safety and achieve a passing score.
8. The Occupational Health Clinic for Ontario Workers (OHCOW), WHSC, ODRT and PSHSA should each continue their unique, supportive prevention functions.
9. WHSC, ODRT and PSHSA should develop training material and standards and oversee delivery of training across the province.
10. The highest government officials, including the Minister of Health and Long-Term Care and the Chair of the WSIB, must openly and clearly communicate a commitment to

occupational health and safety law and principles throughout the health care system, beginning with their own organizations.

11. Senior government and WSIB officials, directors of health care boards and senior health executives must receive mandatory training in occupational health and safety law, principles and personal liabilities. Consideration must be given to augmenting training with mentoring by executives from industries which have demonstrated understanding and are leading in health and safety performance (a system is in place in the U.S. that offers "...mentoring services that match interested facilities with mentors who share safety and health information and provide assistance").⁸
12. Integrate occupational health and safety criteria/requirements into accountability agreements, physician privileges agreements and performance standards/measures for health care employers, officers, directors and managers.
13. Officials who continue to resist law, policy and principles should be held accountable (*see Enforcement section*).
14. Ministries and employers must require occupational health and safety filters before approving funding, contracts, purchasing, etc. Establish enforceable health and safety requirements in contracts for work by contractors.
15. Health care facilities must establish a sustained dollar line for health and safety in their budgets (employers were given one-time funding for lifting devices, but that has not been sustained).
16. Do not grant emergency funding for defence of occupational health and safety law violations (*see Enforcement section*).
17. Ministries of education, universities and colleges and professional colleges thread occupational health and safety throughout school and post-secondary curricula. Justice Campbell made a similar recommendation, but we have seen little progress on this front.

Vulnerable Workers Section

18. Employers should be encouraged to employ steady full-time and part-time workers and not rely on agency workers.
19. A standard for longer, more comprehensive training of JHSC members in the health care (high-risk) sector should be established.
20. Comprehensive orientation and training, developed in consultation with the JHSC, must be administered each time part-time, casual or agency workers commence work in a new unit.
21. The employer must develop and deliver, in consultation with the JHSC, training to all existing full-time employees, part-time, casual and agency staff regarding the worker's rights and avenues for seeking enforcement of those rights.

Joint Health and Safety Committee Section

22. Employers should be made to establish full-time, paid worker health and safety representatives. Many industrial employers, where the public stakes are not as high, have done this, and some of our larger hospital employers have partially funded some time off for worker safety representatives. This needs to be a legislated standard, particularly for high-risk workplaces such as health care.
23. In addition to full-time worker safety representatives, additional worker representatives should be trained to monitor and respond to health and safety issues in each unit (Sault Area Hospital has achieved this standard and reports that it is very successful). This standard should also be legislated, particularly for high-risk workplaces. Many workers are intimidated by attitudes exhibited by "incompetent" supervisors. Therefore, section 28 of the *OHS*A should also be amended to allow workers to report/funnel their concerns, etc. to supervisors through health and safety representatives.

24. The legislation should be amended to expand the investigative powers of JHSCs. Currently, committees are only entitled by law to investigate critical and fatal injuries and we hear that they have to struggle to do this. JHSCs should be embraced as useful vehicles for examining root causes of accidents and injuries and should be trusted to determine when investigations are needed. By failing to investigate trends, near misses and “minor” injuries, we miss opportunities to prevent the critical or fatal injury from occurring.
25. Workers represent the majority on Northern European workplace safety committees and those committees reportedly function well. Ontario law should be amended to provide for worker majority representation on JHSCs.
26. Australian worker safety representatives are empowered to issue Provisional Improvement Notices to employers when they find safety violations in their workplaces; this measure is reportedly effective. Our law should be amended to similarly empower JHSC members.
27. Section 45 of the *OHS*A should be amended to permit a single certified member of the JHSC to stop work in dangerous circumstances.
28. Similar to the Sault Area Hospital model, senior executives should demonstrate commitment to JHSCs by participating on them. Boards of Directors should demonstrate commitment by inviting JHSCs to report to their meetings and by opening their own meetings with safety reports, including the business of the JHSC.
29. JHSCs need funding to operate. Employers need to develop standing budget lines for JHSCs; at least a percentage of any WSIB New Experimental Experience Rating (NEER) rebate should be required to be assigned to the JHSC.
30. The MOL should direct inspectors regularly and in targeted initiatives to enforce the provisions of the *OHS*A related to JHSCs – for example, time to prepare, investigate, inspect, notice, etc. As discussed in the enforcement section, issuing personal orders to

officers, directors and supervisors is an effective way to achieve compliance and inspectors should be directed to do so.

31. Section 25 (1) (a) and 25 (2) (j) should be amended to require JHSC consultation.
32. Section 51 (1) should be amended to require that the written report also be sent within 48 hours to the JHSC, Health and Safety Representative and Trade Union.
33. Safe Work Associations (SWAs), using the Workers' Health and Safety Centre (WHSC) model for certification, should work collaboratively to develop standard curricula, standards for training, delivery of training and monitor compliance with set standards.
34. Legislation should be amended to require certification training for all directors, officers and all JHSC members.
35. Amend training in corporate governance schools to include training on occupational health and safety and personal liability
36. From 1991 to 1995, the now defunct Workplace Health and Safety Agency developed criteria to establish which workplaces required a one-, two- or three-week certification training course, based on payroll and number and type of hazards in the workplace. Legislation should be enacted to reinstitute this requirement.
37. Enact the recommendations in ONA's February 1, 2010 submission to the WSIB regarding the Joint Health and Safety Committee Certification Program Consultation Paper (see *Appendix A, Tab 13*).
38. Transport legislated industrial standards such as pre-start reviews, lifting device inspections and others appropriate to the health care sector by either amending the *Regulation for Health Care and Residential Facilities* to include them or by amending the *Regulation for Industrial Establishments* to extend to all workplaces.
39. Government should provide sustained funding for health and safety initiatives and employers should establish health and safety lines in their budgets.

40. Government should make funding of health care and other workplaces dependent on the application of occupational health and safety/infection control filters, including the consultation of the JHSC and workers, as noted in this submission, to design the elimination of hazards before construction or procurement of equipment, etc.
41. Government should have one business number assigned for each employer and all information, as noted above, should be entered into a common database. Information pertaining to that business should be shared and cross-checked with all system partners for prevention and enforcement activities.

Enforcement Section

42. Promote the inclusion of enforceable occupational health and safety requirements in director and officer accountability agreements, physician privilege agreements and contracts for work by contractors. For the purposes of enforcement of the general duties section of the *Occupational Health and Safety Act*, consider these provisions and their enforcement as ‘reasonable precautions’ for employers to take and issue orders for compliance. Insert this approach into the Ministry of Labour policy and procedures manual for inspectors.
43. Educate and direct inspectors to issue personal orders and initiate personal prosecutions against individual officers and directors to gain their personal attention, especially in health care – a difficult environment with serious, competing priorities. Expand the schedule offences for ticketable offences to include health care employers and supervisors for particular offences.
44. Direct inspectors to consider occupational health and safety provisions of collective agreements as “reasonable precautions” to protect workers and to issue orders under the general duties’ clause of the *OHS Act* when such provisions are violated. Insert this approach into the Ministry of Labour policy and procedures manual for inspectors.
45. Increase worker representation on JHSCs.

46. Empower worker safety representatives to issue enforceable orders against employers who have control of the workplace.
47. Empower trained health and safety representatives to unilaterally stop work when necessary.
48. Take responsibility for prevention from the WSIB and leave it to manage compensation claims.
49. Move responsibility for prevention to the MOL so that reactive and preventive enforcement initiatives and programs:
 - a. can be developed with the common goal of achieving safe and healthy workplaces;
 - b. can be developed based on comprehensive qualitative and quantitative measures;
 - c. can consider injury data based on the reporting requirements of the *OHSA*, capturing all lost-time injuries of limited or extended duration and “near misses” in all workplaces, not just those identified in section 53 of the *OHSA*.
50. Have the WSIB operationalize draft 14 of the occupational health and safety principles document negotiated with the Ontario Federation of Labour (OFL), teach decision makers occupational health and safety law and principles and require them to factor them into their adjudication.
51. The WSIB should teach decision-makers the laws and principles governing evidence so they can safely adjudicate claims and prevent further reinjuries of vulnerable workers.
52. Workwell audits, or a version of them, should be moved to the MOL. As one prevention tool, MOL inspectors should be empowered to order them as a “precaution reasonable” under the general duties’ clause.
53. The MOL should continue its health care focus and enforcement initiatives and prosecution in the health care sector.
54. The MOL should investigate workplace-related motor vehicle injuries for workplace-related root causes and appropriate enforcement responses.

55. The MOL should issue orders under the general duties' section of the *OHSA* for increased staff when investigation reveals that insufficient staff creates a risk in the workplace.
56. Educate police officers about occupational health and safety law and the functions of the MOL, and about health and safety amendments to the negligence sections of the *Criminal Code of Canada (CCC)* and direct them to apply this law, where appropriate. Develop and apply protocols for collaborating and/or communicating when work-related accidents/incidents occur.
57. Extend coverage of the *Regulation for Healthcare and Residential Facilities* to all workplaces within which health care workers work.
58. That the precautionary principle, which states that action to reduce risk need not await scientific certainty, be expressly adopted as a guiding principle throughout Ontario's health, public health and worker safety systems by way of policy statement, by explicit reference in all relevant operational standards and directions, and by way of inclusion, through preamble, statement of principle, or otherwise, in the *Occupational Health and Safety Act*, the *Health Protection and Promotions Act*, and all relevant health statutes and regulations.

Partners in the Occupational Health and Safety System:

Ministry of Labour

Workplace Safety and Insurance Board

Health and Safety Associations

Question:

1. How can the Ministry of Labour, the WSIB and the HSAs be better aligned in terms of service and program delivery?

ONA believes that if the roles of the MOL, the WSIB and the Safe Work Associations (SWAs) were realigned, these entities would be more effective in reducing workplace injuries and illnesses, with cascading impact on patient safety.

Because of high injury rates in the sector (*see below*), employers were familiar with the WSIB prior to SARS, but there was little enforcement activity in the health care sector and many employers were unfamiliar with their sector's SWA. We were aware of only one pursued prosecution in the sector – at North Bay Civic Hospital in 1990 – orders were relatively uncommon, and Ministry of Labour inspections often focused on plant issues. In 2004, as part of a proposed settlement of occupational health and safety grievances, ONA suggested to North Bay General Hospital that it enlist the help of the Healthcare Health and Safety Association (as it was then known), the employer representatives claimed to not know of the Association's existence.

Since SARS, ONA has witnessed significantly increased activity by and an increased profile of the MOL and the Safe Work Association in the sector. We have seen what works and what has not.

ONA believes that the Ministry of Labour should continue its current role of setting and enforcing standards for workplace safety. But ONA takes a broad view of enforcement for

occupational health and safety purposes. Law enforcement agencies typically combine a number of approaches to securing compliance with legislation. Police forces react and respond to complaints and incidents, but also engage in intelligence gathering, research, analysis and trending to develop prevention programs and initiatives and deliver prevention messaging to the public. Enforcement combines reactive and preventive efforts in one agency. It would be hard to imagine a police force divesting itself of responsibility for crime prevention.

Yet health and safety enforcement and prevention have been segregated in Ontario. In 1998, our compensation legislation was revised to invest the responsibility for promotion of health and safety and prevention of workplace injuries and disease in the Workplace Safety and Insurance Board. The Board has had 13 years to make progress in this area, but it has failed miserably on several fronts:

Questionable Intelligence

Genuine prevention measures must be based on accurate statistics which honestly depict the state of health and safety in a workplace. There is much evidence to substantiate that the WSIB is less interested in an authentic picture of workplace safety and more interested in curbing the costs of claims it must finance. Reporting requirements in the *Workplace Safety and Insurance Act (WSIA)* and attendant policies contrasted with those of the *Occupational Health and Safety Act (OHSA)* are revealing. Each has a different purpose and paints a different picture. The major consideration for reporting in section 21 of the *WSIA* is whether a worker is “*not able to earn full wages.*” Wages have nothing to do with capturing the state of occupational health and safety in a workplace. Sections 51 and 52 of the *OHSA*, on the other hand, are confined to considerations of health and safety impact on the worker, with no mention of monetary cost. Even the “near-miss” reporting requirement for projects and mine sites under section 53 of the *OHSA* does not mention money.

The data WSIB/MOL use start from a false premise as policy does not require reporting of some actual injuries (WSIB Policy 15-01-02 – “Employers’ Initial Accident-Reporting Obligations”)⁹ despite the fact that they may arise from serious hazards. Since 1996, the WSIB has also

openly permitted a practice (revised on 06/20/2008 – see *Appendix A – Tab 1 - “Employer Advances – Clarification,” “Executive Summary” and “Recommendations for Experience Rating” by Morneau Sobeco*) that allows employers to refuse reimbursement from WSIB where a worker is temporarily partially disabled and the employer keeps the wage whole. This practice is contrary to WSIB Policy 18-01-11 –“Compensation Advances by Employer.”¹⁰ This practice was then interpreted to allow employers to also inaccurately report the status of lost-time injuries: WSIB has allowed employers to report lost-time injuries as no lost-time if it keeps a worker’s wage whole while on graduated work or reduced hours. The “Employer Advances – Clarification” section of the document, page 2 of 4 (see *Appendix A – Tab 1*) also states, “The Policy on “Calculation: Temporary Partial Disability Benefits” (Operational Policy manual document 05-02-03) provides that if an employer is paying wages to a worker with a temporary partial disability, and the work being performed is worth less than the employer is paying...the employer may choose not to be reimbursed by the WSIB.” Policy 05-02-03 (see *Appendix A – Tab 2*) says no such thing. This clarification document and its contradictory interpretation to WSIB Policy 18-01-11¹⁰ and the Morneau Sobeco Executive Summary and recommendations (see *Appendix A – Tab 1*) are evidence of the manipulative WSIB system, as this practice keeps employers:

- under the radar of the WSIB Firm Selection Model;
- under the radar of WSIB adjudicators who would otherwise have an open claim file on the worker and monitor suitable return to work;
- under the radar of the WSIB New Experimental Experience Rating Program;
- and certainly under the radar of the MOL, as a good portion of these skewed WSIB statistics are used by the MOL to identify employers to target for enforcement initiatives.

The WSIB Experimental Experience Rating Program (NEER) is strictly cost-based and under it, an employer is not even considered by the program (reserve factor) until a worker has been paid by WSIB for one week of lost earnings. Employers who keep a worker’s wage whole and make no health and safety improvements are not properly penalized for poor health and safety performance because the WSIB has permitted it to manipulate the reporting system to hide the cost of claims. (For more information about this manipulative WSIB practice, refer to the “Incentives” section of this submission.)

WSIB's prevention efforts are therefore based on calculations that exclude or minimize a quantity of injuries (e.g. those for which the employer keeps wages whole). Also, these same injuries are discounted when the Board determines whether to apply incentives and penalties.

Such "minor" (or at least inexpensive) injuries arise from exposure to hazards. These injuries are therefore evidence of hazards; these and other factors must be taken into account when attempting to paint an accurate picture of workplace health and safety, and when making informed decisions about prevention. The WSIB motive for excluding "minor" injuries from its database upon which the MOL bases its enforcement activity, and the motive for ignoring no lost-time claims and any claim with less than one week of lost earnings (LOE) in determining rebates and surcharges, can only be cost reduction.

You cannot have effective enforcement in the form of preventive programs and initiatives if you do not strive to honestly evaluate the problem. Police forces arguably strive for order and justice. If their statistics ignored assaults that did not have particular monetary impacts, would their prevention efforts have any hope of being effective? The Ministry of Labour currently bases its sector strategies and enforcement initiatives on faulty WSIB statistics. If the government is serious about workplace health and safety, this cannot continue.

The MOL apparently has not developed its own database from employer accident reports, but unless WSIB alters its view of "injuries" and "reporting" and reflects data that is truly reflective of real health and safety, MOL will need to invest resources in a new database. Employers are currently made to fulfill both reporting obligations (*WSIA* and *OHSA*), so improving what is done with MOL reports would not be an extra burden to employers.

Regardless of the state of injury data, evaluation of occupational health and safety is complex and cannot flow exclusively from analysis of injury data. Several theories about the relationship between the number of "near misses" and "minor" injuries and the statistical predictability of critical incidents¹¹ demonstrate the value of considering all incidents, whether they result in "serious" injury or not. Ignore a "near miss" or a "minor" injury and you neglect an opportunity to prevent a future injury.

The International Labour Office corroborated the complexity of occupational health and safety evaluation when it outlined the elements for performance monitoring and measurement. It suggested that you need:

*both qualitative and quantitative measures appropriate to the needs of the organization...and to...include both active and reactive monitoring, and **not be based only upon work-related injury, ill health, disease and incident statistics;***¹²

Failure to Understand Occupational Health and Safety and Failure to Lead

Even though the WSIB was charged 13 years ago with promoting health and safety and preventing injury and disease, ONA staff were advised in a meeting with WSIB officials in July 2006 that they had never taught occupational health and safety law and principles to their own staff, and that their decision makers were never taught the law and principles with respect to evidence. Numerous ONA members have been reinjured as decision makers failed to properly weigh relevant and material evidence and apply occupational health and safety law and principles (see *Appendix A – Tab 3*). ONA and the OFL brought this to the Board's attention in a series of meetings commencing in 2006. After 14 drafts, the WSIB finally agreed to an occupational health and safety principles document (see *Appendix A – Tab 4*) to be piloted in a workplace with a solid internal responsibility system (IRS). On April 21, 2010, Sault Area Hospital workplace parties met with ONA and WSIB's Chief Operating Officer about launching a pilot on this document. The health and safety-savvy workplace parties selected to pilot this project described the document, which took WSIB years and 14 drafts to accept, as "pretty basic." WSIB, "leaders" in prevention, still have not launched this project.

Ministry of Labour

As will be discussed further in the "Enforcement" section of this submission, ONA advocates that the MOL's role be expanded beyond reactive enforcement to embrace prevention oversight and initiatives, similar to other enforcement agencies. As a starting point, we believe that a bolstered internal responsibility system will serve as a foundation for MOL "enforcement." There

are simply too many workplaces and too few enforcement officers to leave occupational health and safety compliance measures to the MOL. The MOL must identify hazards and cite violations, but can also identify further opportunities for prevention. MOL prevention staff should use all information available to determine when an employer needs assistance in understanding its responsibilities and how to meet them. In addition to orders and prosecution, MOL should be able to order more extensive audits and intervention, similar to the WSIB's current Workwell audit. The Workwell audit is an occupational health and safety prevention tool, and it would be inefficient to leave that sole prevention program at WSIB. The function, or a version of it, should be transferred to the new prevention arm at the MOL.

Safe Work Associations and the Ontario Federation of Labour's Occupational Disability Response Team

Our experience has been with the Workers Health and Safety Centre, the Occupational Health Clinics for Ontario Workers, the Occupational Disability Response Team and the Ontario Safety Association for Community and Healthcare (now PSHSA). Each has offered specialized services to employers and workers to assist their occupational health and safety efforts.

Specifically:

WHSC offers the highest quality of health and safety training and is the only organization designated as a training centre by the WSIB. The centre has a network of instructors, including ONA members, who have completed an intensive adult education course and have extensive experience as members of their own joint health and safety committees. We believe their certification training is superior to any other training as the Centre offers a truly unique hazard-based approach that trains participants to identify hazards, then assess and control or eliminate them. In May 2010, ONA complemented our health and safety training for ONA leaders and health and safety representatives by having the WHSC tailor their investigation module to include the investigation of occupational illness, from exposure to infectious disease. It was well received and members could relate to the presenter because he had actual workplace experience as a Joint Health and Safety Committee worker member.

OHCOW clinics combine resources not available elsewhere. They have multi-disciplinary teams of occupational physicians, nurses, hygienists, ergonomists and administrative professionals. They have the expertise to investigate occupational health conditions – and then to work effectively for prevention. A perfect example of their unique resource is the current joint initiative with OHCOW, the employer, unions, the ODRT, Public Services Health & Safety Association (PSHSA formerly OSACH), and the Institute for Work and Health at Niagara Health System. Without OHCOW's understanding of occupational health and safety law and principles, including the internal responsibility system, combined with their medical and ergonomic expertise, this exciting project with its promising implications for safe return to work in all workplaces, would not be possible.

PSHSA, the health care sector-specific safe work association (formerly OSACH) has provided much-needed focus and expertise in assisting employers with sector-specific issues in occupational health and safety. They have gained credibility with difficult employers in the complex health care sector and are making progress in raising health and safety consciousness with their training and consulting services.

ODRT, although not a safe work association, is an organization that receives funding from the WSIB to provide training and advisory services on workplace insurance and disability prevention. This includes assisting workplace parties with their return to work efforts. Their principles for return to work are based on disability prevention and therapeutic return to work. We have used their services and expertise training ONA staff about safe return to work and in working with the Niagara Health System. It has been a valuable resource. We believe in the next few years, with their assistance, the Niagara Health System will become a model employer in the prevention of injuries and return to work.

Each of these associations has unique and valuable contributions to make in establishing occupational health and safety cultures and preventing illness and injury.

ONA members from every region in the province have complained that occupational health and safety training material and delivery is not consistent. The WHSC, ODRT and OSACH (and counterparts) have the expertise to develop training standards and standard curricula and oversee consistent delivery to workplace parties, and should be charged with doing so. Just as with public school curriculum and teachers, standards must be developed and followed and these organizations are the appropriate agencies to carry out these functions.

As well, the WHSC, ODRT and OSACH have knowledge and expertise that position them well to complement the new prevention arm at the MOL. They should provide assistance to employers who have failed the Workwell audit. When the MOL prevention section identifies an employer that has failed this extensive audit, these agencies should assume the function of improving workplace health and safety and assist these employers to achieve a passing score.

Recommendation:

1. Because, for 13 years, the WSIB has:
 - failed to learn and apply occupational health and safety principles and law to its own operation, with devastating effects on vulnerable, injured workers, and staff have not been trained in occupational health and safety law and principles, nor the rules of evidence, and through their ignorance, decision-makers have actually made decisions which have contributed to reinjury and further injury of workers;
 - generated injury/illness statistics based on cost consideration, which do not accurately reflect occupational health and safety in workplaces, and upon which the MOL improperly bases enforcement activities;

ONA recommends that prevention responsibilities and activities be completely removed from the WSIB, and that WSIB's incomplete statistics not be used for any health and safety enforcement activities.

2. Given WSIB's continued influence over the safe return to work of injured workers, it should train decision makers in the occupational health and safety law and principles (reflected in draft 14 of the principles document, *see Appendix A – Tab 4*), and the rules of evidence,

and apply to decision-making, particularly with respect to safe return to work of vulnerable, injured workers.

3. Expand the MOL's role and like police agencies, charge it with enforcing law through reactive and preventive actions (*see more in "Enforcement" section*). Move prevention to the MOL so that reactive and preventive enforcement initiatives and programs:
 - d. can be developed with the common goal of achieving safe and healthy workplaces;
 - e. can be developed based on comprehensive qualitative and quantitative measures;
 - f. can consider injury data based on the reporting requirements of the *OHSA*, capturing lost-time injuries and "near misses."
4. In order to develop a more accurate picture of occupational health and safety, the MOL should develop its own database of injuries and "near misses" based on the reporting requirements of the *OHSA*. In the alternative, the MOL and WSIB should work together to revise the existing WSIB database to accurately reflect all workplace injuries, regardless of cost and to correct its practices, which currently allow employers to inaccurately report lost-time injuries as no lost-time injuries when the employer keeps the wages whole. Furthermore, employers in Ontario should have one business number assigned to them for all government purposes so information can be cross checked.
5. Revise section 53 of the *OHSA* and related regulations to include requirements for reporting similar "near misses" in other workplaces. For instance, why is it only important for a *constructor* to report "a worker falling a distance of three metres or more," or "a worker becoming unconscious for any reason?"
6. The MOL should use the revised database of injuries and other indicators, including inspections, to identify employers that could benefit from more extensive occupational health and safety audits, and order same.
7. The current Workwell audit function should be removed from the WSIB and transferred to the new prevention arm at the MOL. As one tool for prevention, MOL inspectors should be empowered to order them as a "precaution reasonable" under the general duties' clause.

The WHSC, ODRT and the Public Services Health and Safety Association (PSHSA) should support this function by assisting employers to improve health and safety and achieve a passing score.

8. OHCOW, WHSC, ODRT and PSHSA should each continue their unique supportive prevention functions.
9. WHSC, ODRT and PSHSA should develop training material and standards and oversee delivery of training across the province.
2. What would give employers and workers a better understanding of the roles of the Ministry, WSIB and HSAs?

The roles of these entities need to be realigned as outlined above, then clearly communicated to all. Workers should all receive, as a minimum, health and safety training to understand their right to know, participate and refuse unsafe work and be made aware of the role of the SWAs and ODRT in this training. JHSCs should all be certified and trained to understand who the system partners are and how they can assist JHSCs in carrying out their functions.

3. Can you comment on the effectiveness of the ministry, WSIB and HSAs in preventing occupational injury and illness?

Health care is a complex working environment which presents a myriad of hazards, some common to other workplaces, some peculiar to health care settings. The hazards include:

- “industrial” hazards such as those posed by machines, electricity and other “plant” equipment;
- ergonomic hazards ranging from patient lifting to improper computer stations (causing musculoskeletal injuries);
- harmful chemicals and pharmaceuticals, e.g. cleaning and disinfecting solutions, anesthetic gases, glutaraldehyde, antineoplastic drugs, antibiotics, etc.;

- exposure to infectious disease through airborne and contact transmission and from sharps and needlestick injuries;
- violence;
- stress;
- overwork and understaffing that leads to physical, emotional and psychological injury, illness and “burnout;”
- exposure to radiation from radiotherapy procedures;
- motor vehicle accidents.

Additionally, health care workers’ risk of reinjury is high when (ignoring the principles of disability prevention) disabled workers are rushed to return to work that is not safe for them.

Statistics suggest that, while workplace injury rates are generally dropping, the reverse is happening to workers in the health care sector. For instance, between 1999 and 2006, lost-time claims in the Ontario health care sector rose from 7.0 to 10.1 per cent.¹³ According to Statistics Canada, in 2007, full-time employees in health occupations recorded the most days off for illness or disability in the entire workforce.¹⁴

Aside from personal costs, high absenteeism rates strain the health care system. In its 2005 annual report, the Institute for Work and Health cited one estimate that Canadian nurses lose more than 16 million hours annually for injuries and illnesses.¹⁵ Safe and healthy workplaces may prevent many costly injuries and divert much-needed funds to patient care. But while injury and illness rates are steadily decreasing in workplaces traditionally considered dangerous, such as mines and factories, these rates continue to climb in the health care sector.¹⁶ ONA believes that a strategic focus on health and safety and a resultant prevention of illness and injury will reduce significant costs for the system.

Given the evidence, ONA believes that the current arrangement of health and safety system partners has not been as effective as it could be. Accordingly, we offer the above recommendations for improvements.

4. What shortcomings, gaps or duplication of services should be addressed by this review?

See above.

5. Should stakeholders and other organizations, such as private foundations and non-government organizations, be involved in the planning and design of occupational health and safety system initiatives, and if so, how?

ONA believes that we have valuable insight into the real working conditions of our members and the hazards and challenges they face in striving for healthy and safe workplaces. We therefore believe that SWAs must restructure and ensure that there is a bipartite board of directors, similar to the structure set out in British Columbia with the Occupational Health and Safety Agency for Healthcare (OHSAH). Our colleagues at the BC Nurses' Union have praised this system and the OHSAH website states "...bipartite governance has been effective in achieving union and front-line worker buy-in for programs designed and delivered by OHSAH, which is crucial for improving workplace health and safety." It is our position that for a system to be truly effective, it should consist of equal members from labour and employer associations.

Another example of how a bipartite system works is the Minister of Labour's Sector Advisory Committee for Healthcare under section 21 of the *OHSA*. This committee works extremely well to identify hazards and trends and develop recommendations to the Minister of Labour and guidance notes for all stakeholders to use to improve safety for all workers in the health care system

We also believe that the labour movement in general should have the opportunity to be involved in the planning and design of any health and safety initiative. For instance, over the last few years, the MOL returned to engaging stakeholders for input on their sector plan. This has proven to be a valuable opportunity to raise concerns and trends. As a result, we have seen many enforcement strategies developed based on our feedback.

Injured worker groups and other non-unionized workers should also have input into health and safety initiatives as they hold a wealth of knowledge that, if shared, could build a

better platform for protecting workers from the hazards in their workplaces and ensuring that those who are injured are not reinjured because of unsafe WSIB practices and policy.

6. What enforcement strategies could be used to improve compliance with legislation, codes and standards?

See section on “Enforcement.”, page 60.

7. Should the government use administrative penalties as another enforcement tool and what sort of violations should these penalties be applied to?

Administrative penalties are generally regarded as a quick and less-costly way to implement regulatory sanctioning. ONA believes that administrative penalties can provide efficiency and flexibility in comparison to criminal enforcement. A number of studies reveal that regulators are more likely to take enforcement action when administrative penalties are available as an enforcement tool, as opposed to when prosecution is the only option. The prosecution process within the MOL requires significant time and resources, beginning with the inspector. There is also evidence that using administrative sanctions has been effective in promoting regulatory compliance.

ONA opposes administrative penalties for serious regulatory violations. These include violations which have either caused or had the potential to cause critical or fatal injuries, as well as cases involving a repeat offender. Such serious breaches should be subject to prosecution. We also favour an administrative penalty regime which allows for parallel proceedings in order to give the regulator the option of either prosecuting the offence under *Provincial Offences Act* or imposing an administrative penalty.

We refer you to Ramani Nadarajah’s article, “Environmental Penalties: New Enforcement Tool or the Demise of Environmental Prosecutions”¹⁷ which critiques the pros and cons of using administrative penalties with regards to environmental violations. The analysis is also applicable to other types of regulatory offences.

8. What can the government do to ensure that other ministries consider occupational health and safety implications when they are making decisions?

As mentioned above, the health care sector contains some of the most complex working environments in the province. Not only is it replete with “common,” industrial-type and more “exotic” hazards, some of which are listed under question 3 above, it has some complicated organizational characteristics.

In his SARS Commission report, Justice Campbell painted a bleak picture of the state of the health care system. He wrote:

“The public health system was broken, neglected, inadequate and dysfunctional. It was unprepared, fragmented, uncoordinated. It lacked adequate resources, was professionally impoverished and was generally incapable of fulfilling its mandate.”¹⁸

He found occupational health and safety, infection control and public health sections of health care working as “silos” and internal responsibility systems and joint health and safety committees were not working. *“Those in charge were poorly informed and inadequately advised”* and employers and government officials refused to heed input and expertise from occupational health and safety experts.¹⁹ He found leadership and communication problems all the way up to the heights of government.

While work is continuing and there was evidence of progress in the province’s response to the recent H1N1 outbreak, much remains to be done to address the problems described by Justice Campbell. The *OHSA* has applied to health care sector employers since its inception in 1978, yet they have remained strangely resistant to occupational health and safety. Even after Ontario’s dismal experience with SARS, infection control and public health experts continued to shut out occupational health and safety expertise. For instance, it was not until a scientific consensus meeting convened by the Public Health Agency of Canada in October of 2006 that government public health and infection control officials acknowledged the value of occupational health and safety expertise when dealing with airborne disease. At this meeting, which ONA

staff attended, there was consensus that occupational health and safety experts be included in the work of developing the infection control chapter of the National Pandemic Plan.

Nevertheless, leaders in the sector continue to openly and quietly resist occupational health and safety. At a meeting of senior health care executives and senior Ministry of Health and Long-Term Care and other officials held April 1-2, 2009, at the “Ideas Panel on Pandemic Preparedness” at Kingbridge Centre, King City, the use of respirators was ridiculed and a senior executive divulged that many in the room regarded Justice Campbell’s SARS Commission report as “emotional.” During the recent H1N1 outbreak, one medical officer of health openly defied Ministry of Labour direction to provide workers with appropriate personal protective equipment and appealed an MOL order to do so. In his affidavit, he swore that, *The Chief Medical Officer of Health for Ontario, Dr. King, has indicated to me and other medical officers of health in her weekly teleconference of October 23, 2009 that in her opinion, N95 respirators and eye shields are not necessary for this type of setting. In fact, they are inappropriate in this setting because they cause unnecessary concerns among clients and discourage people from attending the clinics*” (see Appendix A – Tab 5). During the H1N1 outbreak, we also received anecdotal information from other medical officers of health and other officials presenting barriers to protection. One medical officer of health reportedly commented to a worker that she could have a respirator if she ‘was paranoid enough’ to want to have one.

This attitude has been reflected among officials throughout the sector.

Enforcement agencies have also reflected the notion that some risks are just “part of the job” in health care. It is our understanding that police officers have not been trained in the “Westray” sections of the *Criminal Code of Canada*, and in some instances have not responded to calls for help in violent situations because of their own safety considerations (see Appendix A – Tab 6).

The sector also has other challenges not faced by other workplaces in the province. Not only are nurses and other regulated professionals constrained by their professional college obligations, under the *OHSA*, they only have a restricted right to refuse unsafe work. The health care professions also attract people who tend to “...*compromise personal safety in order to improve the lives of the people they work for. It is possible that this acceptance of a heightened*

sense of duty, at all levels in the system, is a contributing factor to the challenge of improving health and safety performance in the health sector.”²⁰ Large industries and other employers have long accepted that health and safety needs to be part of an organization’s core culture, not just an afterthought, “...but there is little evidence to indicate that OH&S is being more broadly integrated into the practice of health care.”²¹

We are not aware of any other sector that treats unsafe behaviour in as special a fashion as this sector approaches physicians. The College of Physicians and Surgeons has developed a program and *Guidebook for Managing Disruptive Physician Behaviour*. We receive reports ranging from verbal abuse to physical abuse to worse by some physicians across the province. The response by employers and the college underscore the peculiarities of this sector. It is hard to imagine the development of a *Disruptive Plumber Behaviour* program for use when a plumber exhibits violent behaviour in the workplace.

Despite the extra challenges, workers in this sector cannot wholly rely on the courts to protect them, as evinced by the Supreme Court’s decision to deny appeal of a lower court’s dismissal of a SARS class action suit. The Ontario Court of Appeal ruled that the province owed no “private law duty of care” to nurses during SARS.

As indicated above, the stakes are high in the health care sector. ONA strongly believes that if we can establish a culture of occupational health and safety in our workplaces, there will be direct, positive impact on patient safety. The cited Yassi article links worker and patient safety: “...according to the *Canadian Adverse Events Study* approximately 7.5 percent of Canada’s 2.5 million hospital patients experienced at least one adverse event in 2000 and up to 23,750 patients died as a result...Many of these events were potentially preventable...Workers in high-injury rate facilities...were more likely to report that they did not have time to get their work done, to work safely, to find a partner, or to use a mechanical lift...Conversely, workers at facilities with low injury rates were more likely to agree that their facility had enough staff to provide good quality care and did indeed provide good to excellent care.”²²

Given the complexity of the physical environment, the peculiarities of the organizational environment, the history of resistance to occupational health and safety and the limits of court

intervention, the government must take particular actions in this sector. Not only is there a need to realign the partners in the system, standardize and expand training, enhance JHSC powers and rights and improve data collection and enforcement, (see “*Enforcement*” section of *submission*) but the government needs to lead the health care sector by example, by direction and monetary incentive. Until the message clearly rains down from the top, individuals such as these resistant medical officers of health described above may continue to believe that they can disregard ministry directives and the law (see *Appendix A – Tab 7*).

Recommendations:

10. The highest government officials, including the Minister of Health and Long-Term Care and the Chair of the WSIB, must openly and clearly communicate a commitment to occupational health and safety law and principles throughout the health care system, beginning with their own organizations.
11. Senior government and WSIB officials, directors of health care boards and senior health executives must receive mandatory training in occupational health and safety law, principles and personal liabilities. Consideration must be given to augmenting training with mentoring by executives from industries which have demonstrated understanding and are leading in health and safety performance (a system is in place in the U.S. that offers “...mentoring services that match interested facilities with mentors who share safety and health information and provide assistance.”)²³
12. Integrate occupational health and safety criteria/requirements into accountability agreements, physician privileges agreements and performance standards/measures for health care employers, officers, directors and managers.
13. Officials who continue to resist law, policy and principles should be held accountable (see *Enforcement* section).

14. Ministries and employers must require occupational health and safety filters before approving funding, contracts, purchasing, etc. Establish enforceable health and safety requirements in contracts for work by contractors.
15. Health care facilities must establish a sustained dollar line for health and safety in their budgets (employers were given one-time funding for lifting devices, but that has not been sustained).
16. Do not grant emergency funding for defence of occupational health and safety law violations (*see Enforcement section, page 60*).
17. Ministries of education, universities and colleges and professional colleges thread occupational health and safety throughout school and post-secondary curricula. Justice Campbell made a similar recommendation and we have seen little progress on this front.

Vulnerable/Prekarious Workers

Questions

1. Who would you consider to be a vulnerable worker?

We are aware that the concept of “vulnerable/prekarious” workers usually refers to work with questionable job security and wages and protections against dismissal, mistreatment and hazardous work. As confirmed by Justice Campbell in his 2007 SARS Commission report, there has been insufficient health and safety protection for all workers in the health care sector. Health care workers in general are at greater risk of injury and illness than most of the workforce. Health care is among the top four sectors in the frequency of lost-time injuries, ahead of construction and mining. In the context of this discussion about occupational health and safety, some of our members are particularly vulnerable:

- Part-time and casual workers;
- Agency workers;
- Students (and volunteers);

- Injured workers.

Our members report that these workers are least likely to receive training in health and safety hazards and protections, and most likely to move about in a workplace.

2. How can government require and/or motivate employers to protect the health and safety of these workers?

Lead by example (*see previous section, particularly recommendations 10-17, page 30*).

In the past, suggestions have been made that “social marketing” tools be used to make workplace injuries socially unacceptable and not just “part of the job.” The drop in public acceptance of smoking and driving while intoxicated were cited as two examples of shifts in values. Arguably, the change in attitude towards those issues, and seatbelts, was more attributable to advancements in scientific knowledge, widespread dissemination of real information and education about the hazards of those behaviours and stronger legislation and enforcement. Social marketing is a slap of paint on a wall that needs to be rebuilt.

Likewise with occupational health and safety issues. Health and safety cultures are best established when there is a full-time or at least regular workforce which is given initial and ongoing training in all the hazards and protections inherent in their work. When the employer does resort to the use of casual and agency workers, the employer must be made to understand and fulfill its responsibility to ensure occupational health and safety protection for all workers.

A high-risk workforce such as exists in health care should receive especially rigorous training in hazards, protections, laws, rights and responsibilities. Because their environments are so complex and hazards varied and injuries frequent, there should be a standard that joint health and safety committees in particular receive longer and more comprehensive training. Also, a casual or transient workforce needs to be trained about worker rights and obligations and given solid legislative and enforcement backing when they do raise issues. Construction and other contractors routinely receive comprehensive health and safety orientation for each project or other site at which they work. Our members report that agency nurses may receive one hour of orientation the first time they

work at a health care facility. Our members and casual nurses and other staff often float to other areas of the facility with no orientation or safety training about issues such as lifting hazards in the particular unit, oxygen tanks, infectious diseases, etc.

Students can be particularly vulnerable. They often engage in meaningful work during school placements. The vulnerability of their situation was underscored during the recent H1N1 outbreak, when we received reports that students had to purchase and arrange their own respiratory protection, students were not advised of protocols to access equipment and orientation and education was weak and inconsistent from one facility to the next.

As indicated earlier in this submission, numerous ONA members have been reinjured as WSIB decision makers failed to properly weigh relevant and material evidence and apply occupational health and safety law and principles. Protections for workplace injured and other disabled workers are necessary to prevent further injury and illness when returning to work. In 2006, ONA captured injured workers' plights in a report to our Biennial Convention (*see Appendix A – Tab 8*).

3. Could anonymous complaints be effective in enforcing health and safety compliance to protect vulnerable workers?

Certainly, anonymous complaints would be one vehicle for ensuring the safety and health of vulnerable workers. However, depending on the size and arrangement of the health care facility, anonymity may only be illusory. Enforcement agencies need to do preventive work, analyse data and indicators, identify employers with vulnerable workers and/or employers when there is evidence that they are failing to protect vulnerable/high-risk workers, and invest proactive enforcement efforts at these workplaces.

Recommendations

- 18 Employers should be encouraged to employ steady full-time and part-time workers and not rely on agency workers.

- 19 A standard for longer, more comprehensive training of JHSC members in the health care (high-risk) sector should be established.
- 20 Comprehensive orientation and training, developed in consultation with the JHSC, must be administered each time part-time, casual or agency workers commence work in a new unit.
- 21 The employer must develop and deliver, in consultation with the JHSC, training to all existing full-time employees, part-time, casual and agency staff about the worker's rights and avenues for seeking enforcement of those rights.

(See also recommendation 2 in Partners section of submission, page 21)

Incentives/Supply Chains

Questions

1. What are reliable indicators of health and safety conditions in workplaces?

Evaluation of occupational health and safety conditions, particularly in the complex working environment common to health care, can be very complex. There is a myriad of indicators and they should not be considered in isolation of one another. The International Labour Organization (ILO) corroborated the complexity of occupational health and safety evaluation when it outlined the elements for performance monitoring and measurement.²⁵

It says you need:

*both qualitative and quantitative measures appropriate to the needs of the organization...and ...include both active and reactive monitoring, and **not be based only upon work related injury, ill health, disease and incident statistics;***

The complexity of evaluation is illustrated by this more complete excerpt from the ILO guidelines:

3.11. Performance monitoring and measurement

3.11.1. *Procedures to monitor, measure and record OSH performance on a regular basis should be developed, established and periodically reviewed. Responsibility, accountability and authority for monitoring at different levels in the management structure should be allocated.*

3.11.2. *The selection of performance indicators should be according to the size and nature of activity of the organization and the OSH objectives.*

Evaluation

3.11.3. *Both qualitative and quantitative measures appropriate to the needs of the organization should be considered. These should:*

- (a) be based on the organization's identified hazards and risks, the commitments in the OSH policy and the OSH objectives; and*
- (b) support the organization's evaluation process, including the management review.*

3.11.4. *Performance monitoring and measurement should:*

- (a) be used as a means of determining the extent to which OSH policy and objectives are being implemented and risks are controlled;*
- (b) include both active and reactive monitoring, and not be based only upon work related injury, ill health, disease and incident statistics; and*
- (c) be recorded.*

3.11.5. *Monitoring should provide:*

- (a) feedback on OSH performance;*
- (b) information to determine whether the day-to-day arrangements for hazard and risk identification, prevention and control are in place and operating effectively; and*
- (c) the basis for decisions about improvement in hazard identification and risk control, and the OSH management system.*

3.11.6. *Active monitoring should contain the elements necessary to have a proactive system and should include:*

- (a) monitoring of the achievement of specific plans, established performance criteria and objectives;*
- (b) the systematic inspection of work systems, premises, plant and equipment;*
- (c) surveillance of the working environment, including work organization;*

(d) surveillance of workers' health, where appropriate, through suitable medical monitoring or follow-up of workers for early detection of signs and symptoms of harm to health in order to determine the effectiveness of prevention and control measures; and

(e) compliance with applicable national laws and regulations, collective agreements and other commitments on OSH to which the organization subscribes.

3.11.7. *Reactive monitoring should include the identification, reporting and investigation of:*

(a) work-related injuries, ill health (including monitoring of aggregate sickness absence records), diseases and incidents;

(b) other losses, such as damage to property;

(c) deficient safety and health performance, and OSH management system failures; and

(d) workers' rehabilitation and health-restoration programmes.²⁴

2. What motivates employers to constantly improve their health and safety performance?

What *should* motivate employers is their value system. In 2001, U.S. Treasury Secretary Paul O'Neill delivered a controversial speech about his experience in industry. He said;

"What's needed is for 'safety to be as automatic as breathing...It has to be something unconscious almost...Safety is not a priority at [his company], it is ...a precondition...If a hazard needs to be fixed, it's understood by supervisors and employees that you do it today. You don't budget for next year.'"...O'Neill told his financial people, "If you ever try to calculate how much money we save in safety, you're fired." Why? He didn't want employees looking at safety as a "management scheme" to save money. "Safety needs to be about a human value Cost savings suggest something else. Safety is not about money; it's about constantly reinforcing its value as... a precondition."²⁵

Having said that, we understand that particularly in health care where costs are soaring and there are innumerable competing interests for money, safety is rarely considered. When it is, the prime motivator is money. There are many examples. As indicated earlier,

ONA staff was told by the CEO of a large hospital that he would establish occupational health and safety as a priority if it was one of his accountabilities in his performance contract. In the last two years, Niagara Health System was surcharged \$1.7 million by WSIB and as a result, management is working with unions and others to change the culture of safety and develop a safe return-to-work protocol for injured workers. At a recent meeting, the employer announced that their Board of Directors for the first time made occupational health and safety a part of the CEO's performance measures. The CEO subsequently made safety a performance standard for her Vice-President of Human Resources.

Enforcement and prosecution is another powerful motivator.

3. Should Ontario continue to have a system of incentive programs to motivate organizations to go beyond minimum standards of health and safety? If so, what indicators or activities such as operation of an occupational health and safety management system should be used to verify that a workplace is a superior health and safety performer? How should such incentive programs be administered?

ONA wishes that Ontario's health care sector would embrace occupational health and safety as an unconscious core value, as "automatic as breathing ...a precondition." We wish that our members worked in an environment that did not need any incentive programs to motivate employers to exceed minimum standards. The reality is that our sector is lagging decades behind the rest of the workforce when it comes to health and safety. As such, we need aggressive measures to jumpstart a health and safety culture.

In this context, ONA actually sees value in a system of incentive programs that penalizes employers for poor health and safety performance. Our experience with the Niagara Health System underscores the value of using surcharges for penalizing poor performance as part of a comprehensive incentive/penalty program that incorporates monetary penalties, rebates for only exemplary performance and enforcement action such as orders and prosecution, as well as strong internal responsibility systems bolstered by occupational health and safety management systems.

We do, however, have grave concerns about the incentive program that is currently administered, and the agency that runs it. As explained, it is dangerously based on a system of evaluation that virtually ignores the constellation of factors that the ILO suggests need to be considered to properly evaluate health and safety performance. The single factor that is calculated, lost-time injuries, is not even properly determined. In practice, as mentioned earlier in this submission, WSIB has allowed employers to report lost-time injuries as no lost-time injuries if it keeps a worker's wage whole while on graduated work or reduced hours (*see Appendix A – Tab 1*).

This practice keeps employers:

- under the radar of the WSIB Firm Selection Model;
- under the radar of WSIB adjudicators who would otherwise have an open claim file on the worker and monitor suitable return to work;
- under the radar of the MOL as a good portion of these skewed WSIB statistics are used by the MOL to identify employers to target for enforcement initiatives.

This practice also allows employers to hide actual injury costs, which in turn allows a manipulation of the experience rating system that then rewards employers versus surcharging the employer. These employers escape making health and safety improvements because there is no incentive to do otherwise. They receive rebates, which amounts to being rewarded for poor performance!

Imagine if the WSIB was sincere about preventing injuries. Over the last 13 years, had WSIB followed its current policy on advances which requires all employers to be reimbursed for advances, those costs would have become part of the calculation for experience rating purposes. Based on reports we receive from our members at least in health care, more employers would have been surcharged (which would certainly reduce the unfunded liability) resulting in a greater willingness to make true health and safety changes. The WSIB surcharge cost of not making those changes is much higher than the cost of investing in health and safety. A system based on skewed statistics is designed to contain injury claim costs and is virtually of no value in assessing a workplace's health and safety performance.

While ONA would endorse a properly administered system of incentives based on legitimate injury data combined with the myriad of qualitative and quantitative indicators listed by the ILO, we cannot endorse the continuance of the current system or the continued administration of such a system by the WSIB, which has demonstrated complete health and safety ineptitude both within its own organization, and callously in relation to vulnerable, injured workers.

4. Should there be incentive programs directed at parties other than employers, such as supervisors and workers?

ONA does not support incentive programs that reward workers or others for not having injuries. This kind of system is conducive to hiding injuries, intimidating for those who are injured, and arguably – contrary to the *Human Rights Code* – for denying rewards to those who become disabled. This kind of approach does not properly value or promote true health and safety.

5. Is there an incentive program currently in place in another jurisdiction that you would recommend as a best practice which rewards superior health and safety performance?

ONA is unaware of an incentive program that we could recommend.

6. Should there be non-monetary incentives? If so, what form should such incentives take?

ONA supports recognizing health and safety achievements in the workplace and throughout the sector and elsewhere. Accomplishments can be celebrated and showcased without making a contest or reward system. Workplace parties can be proud when they have truly safe and healthy workplaces in which safety is a core value. The Order of Canada is a “reward” for meritorious service for which a recipient can feel legitimate pride without monetary incentive. The Ontario civil service has rewards for exemplary service. Similar awards for health and safety accomplishment would be appropriate non-monetary incentives.

7. How can accountability for compliance with the law be ensured when goods and/or services are purchased through a chain of contracts and sub-contracts?

As recommended elsewhere in this submission, and also recommended in the ILO *Guidelines on Occupational Safety and Health Management Systems*, contracts for goods, services, equipment, etc. should all contain enforceable occupational health and safety provisions which suppliers and contractors must comply with or forfeit their contract and jeopardize future opportunities for work/business. It is our understanding that such arrangements are common in large industries. In the enforcement section of our submission, we even proposed that for the purposes of enforcement of the general duties' section of the *Occupational Health and Safety Act*, consider these provisions and their enforcement as 'reasonable precautions' for employers to take and issue orders for compliance. Insert this approach in the Ministry of Labour policy and procedures manual for inspectors.

8. Should government encourage and support the development of supply chain incentives and, if so, how?

See above.

Also, the government should lead by example. This means that both the scope and terms of procurement documents and the supply chain relationships should uphold the highest standards internally. For example, in contracting for flu vaccine - which the government does annually - it should require that the delivery device be safety-engineered syringes and this requirement should be applied both to manufacturers supplying the government directly and to any sub-contracted organizations. All contractors and sub-contractors should have to demonstrate that they are supplying goods that meet the highest standards applicable to the goods being procured – i.e., the latest generation safety-engineered medical devices.

The second part of our concern is that whenever the government contracts for goods or services, it should require that contractors and sub-contractors be fully compliant with the

law and government standards in the areas of environmental, occupational health and safety and other relevant standards.

Joint Health and Safety Committees/Internal Responsibility System

Questions

1. Is a JHSC an effective mechanism to prevent workplace injury and illness?

ONA believes that a JHSC properly constituted, led, empowered and resourced could indeed be an effective mechanism to prevent injury and illness. However, given the state of health care sector occupational health and safety attitudes and performance confirmed by the Campbell report (*see Partners section of submission*), we know of very few effective JHSCs in the health care sector. Sault Area Hospital's JHSC seems to be one rare exception. In a demonstration of commitment, the hospital CEO reportedly sits on the committee and conducts workplace inspections alongside workers. This workplace saw some injury reduction when it pioneered a "zero lift" policy. (*see Appendix A – Tab 9*).

At Timmins District Hospital, the JHSC has also progressed and worked to improve health and safety in that workplace. All directors, managers and coordinators completed basic certification training there by April, 2008. (*see Appendix A – Tab 10*).

2. How can JHSCs make effective contributions to workplace health and safety?

JHSCs have a number of powers that can be exercised to improve workplace health and safety, but we hear from union leaders and health and safety activists across the province that most of our members do not receive sufficient information, training, support and time to perform their duties and exercise their powers:

- Current legislation allows workers to monitor health and safety by inspecting the workplace. Yet we receive constant reports of workers who are overworked, with supervisors who do not facilitate inspections and other committee work. Inspections either are often not done, or are rushed.

- Workers are entitled to caucus before JHSC meetings, but we know from quarterly teleconferences with networks of health and safety activists (corroborated by other reports) that our members are not doing this. They are not replaced to attend meetings, so colleagues are overworked in their absence, or their work awaits their return. They do not have and are not given the time to caucus, nor often to attend meetings. They therefore often attend meetings unprepared. Anecdotal reports were corroborated by a recent ONA survey of Bargaining Unit Presidents and JHSC members that found that “50 per cent rarely or never caucus before every JHSC meeting” (see *Appendix A – Tab 11*).
- JHSC worker members have the right to conduct critical and fatal injury investigations, but rarely do. In fact, many health care employers do not even report injuries in accordance with the notice provisions of the *OHSA*. ONA is in a running battle with employers around the province who erroneously assert that they need not provide details of accidents and injuries because to do so would violate privacy rights. We have sought the support of the Ministry of Labour (see *Appendix A – Tab 12*) but continue to meet resistance. This also was confirmed by ONA’s recent survey, where 64.4 per cent of respondents reported their employers do not give JHSCs written notice of injuries and illnesses, as required by law (see *Appendix A – Tab 11*).
- Committees are empowered to make written recommendations to employers but we know from anecdotal information that they rarely do. This was corroborated by the survey. Only 37 per cent always submitted recommendations for unresolved concerns because, they said, they do not have enough time to prepare arguments and evidence to support recommendations. Where recommendations were submitted, 70 per cent said the employer always or most of the time resolved the health and safety concerns. Based on these survey results, there is clear value in writing recommendations to the employer. At the Niagara Health System, JHSC members – frustrated because of a lack of ability to move health and safety issues forward at the committee – sought assistance from ONA staff. Employer representatives of the JHSC were simply deferring issues or just refusing to forward recommendations to the employer, often citing cost. At a meeting held in May, 2009, staff invited OPSEU and SEIU representatives and documented all unresolved

health and safety concerns, then translated those to a written recommendation with three key issues. Each site was told to tailor the recommendation to the needs of their specific workplace and table the recommendation at their next JHSC meetings. Just prior to the meetings, the ONA Bargaining Unit President met with the employer's Vice-President and alerted him to this initiative. She advised that JHSC employer members needed to support the recommendations or ONA would call the MOL to report non-compliance with the *OHS*A and dysfunction of the JHSC. Thereafter, all recommendations at all sites were forwarded to the employer without resistance. The employer did satisfactorily reply to most of the recommendations and has resolved many of the outstanding issues.

- JHSC members and any worker can call the MOL when health and safety concerns are not resolved. Yet we know from anecdotal information that this is rarely done. This was also confirmed in the survey. Reasons for refraining from using this part of the external responsibility system vary. The survey found that many did not know they could call.
- We have also received reports of workers who feel intimidated about raising concerns, let alone calling enforcement agencies or exercising their *limited* right to refuse unsafe work. Unsurprisingly, given the state of health and safety knowledge and understanding in this sector, supervisors here are not usually “competent” as defined in the *OHS*A. As such, they are often not receptive to expressions of health and safety concerns. We have heard of supervisors who tell workers that health and safety matters are to be raised to the JHSC, not the supervisor. The fear of reprisal is real in our workplaces.

Not only are JHSC powers not being exercised, but even if they are, given the state of health and safety in this high-risk sector, they would not be sufficient to achieve safe and healthy workplaces. This sector is decades behind in its health and safety performance. Aggressive measures will be needed to bring the sector to a level expected in “mines and factories.” But as Justice Campbell and Dr. Yassi pointed out, even more is at stake in this environment. Health care workplaces that are safe for workers have ripple effects for patients. At a recent ONA training session on infection control and occupational health

and safety, the Director of Infection Control for the Ontario Agency for Health Protection and Promotion said his agency regards worker and patient safety as indivisible.

In order to make the gains that workers and patients need, JHSCs should be given additional powers and support.

Recommendations

22. Employers should be made to establish full-time paid worker health and safety representatives. Many industrial employers where the public stakes are not as high have done this, and some of our larger hospital employers have partially funded some time off for worker safety representatives. This needs to be a legislated standard, particularly for high-risk workplaces such as health care.
23. In addition to full-time worker safety representatives, additional worker representatives should be trained to monitor and respond to health and safety issues in each unit (Sault Area Hospital has achieved this standard and reports that it is very successful). This standard should also be legislated, particularly for high-risk workplaces. Section 28 of the *OHSA* should also be amended to allow workers who may be intimidated by attitudes exhibited by “incompetent” supervisors to report/funnel their concerns, etc. to supervisors through health and safety representatives.
24. The legislation should be amended to expand the investigative powers of JHSCs. Currently, committees are only entitled by law to investigate critical and fatal injuries and we hear they have to struggle to do this. JHSCs should be embraced as a useful vehicle for examining root causes of accidents and injuries and should be trusted to determine when investigations are needed. By failing to investigate trends, near misses and “minor” injuries, we miss opportunities to prevent the critical or fatal injury from occurring.
25. Workers represent the majority on Northern European workplace safety committees, and those committees reportedly function well. Ontario law should be amended to provide for worker majority representation on JHSCs.

26. Australian worker safety representatives are empowered to issue Provisional Improvement Notices to employers when they find safety violations in their workplaces; this measure is reportedly effective. Our law should be amended to similarly empower our JHSC members.
27. Section 45 of the *OHS*A should be amended to permit a single certified member of the JHSC to stop work in dangerous circumstances.
28. As in the Sault Area Hospital model, senior executives should demonstrate commitment to JHSCs by participating on them. Boards of Directors should demonstrate commitment by inviting JHSCs to report to their meetings, and by opening their own meetings with safety reports, including the business of the JHSC.
29. JHSCs need funding to operate. Employers need to develop standing budget lines for JHSCs, and at least a percentage of any WSIB NEER rebate should be required to be assigned to the JHSC.
30. The MOL should direct inspectors regularly and in targeted initiatives to enforce the provisions of the *OHS*A related to JHSCs – for example, time to prepare, investigate, inspect, notice, etc. As discussed in the enforcement section, issuing personal orders to officers, directors and supervisors is an effective way to achieve compliance and inspectors should be directed to do so.
31. Section 25 (1) (a) and 25 (2) (j) should be amended to require JHSC consultation.
32. Section 51 (1) should be amended to require that the written report also be sent within forty-eight (48) hours to the JHSC, health and safety representative and trade union.

Justice Campbell pointed out that during SARS, authorities suffered by not acknowledging and accessing worker and union information and expertise in occupational health and safety. Progress has been slow on this front. Expanding the role and the powers of the JHSC would help to accelerate badly needed improvements in workplace health and safety.

3. What leadership behaviours are expected from a JHSC?

JHSC leadership behaviours will likely reflect the leadership culture of an organization. Ideally, JHSC members will demonstrate:

- a passion for health and safety;
- commitment to the committee and to improving workplace safety and health;
- monitoring of the state of health and safety;
- consultation of workers and experts about concerns and solutions;
- collaboration with workplace parties and experts to get the job done;
- a celebration of successes and recognition of performers.

However, as described earlier in this submission, many employers in the health care sector have demonstrated ignorance of, and outright resistance to, occupational health and safety law and principles. The track record of the sector as reported by the SARS Commission is poor. These employers have not typically demonstrated any of the leadership behaviors listed above, and unsurprisingly, with rare exception, neither have their JHSCs.

Leadership behaviours from a JHSC would only be expected if directors and officers of health care facilities (and the MOHLTC) publicly committed to champion health and safety and affirmed their intentions by fully funding, resourcing and supporting the work of the JHSCs. Such leadership might be helped along if enforcement actions were personalized and directed at health care officers and directors.

4. What measures could be used to ensure that JHSCs exist and function effectively at workplaces where they are required?

See above.

5. What impediments are there to the effective functioning of a JHSC within the internal responsibility system?

In addition to the foregoing, JHSCs need access to resources and expertise. Oftentimes committee members can discern a problem in their workplace and propose solutions, but particularly in as complex an environment as health care, the analysis and resolution may

require the input of specialized expertise. Access to Safe Work Association services should therefore be widely communicated and made available at no cost. OHCOW, with its multi-disciplinary teams of experts, is a particularly valuable resource that must be easily available, especially in health care. Given the frequency of issues with return to work of disabled workers, the Occupational Disability Response Team is another resource that should be widely available at no cost to the employer.

6. Is the current system of certification training adequate and if not, what is needed to make it more effective?

In 2007 Justice Campbell, describing the situation in 2003, reported deficiencies in occupational health and safety training and recommended that senior management be trained about JHSCs, and that JHSCs themselves be properly trained.²⁶ Our members tell us that training lacks standard curricula, uniform length and quality of delivery. ONA believes that we will not see health and safety cultures grow in health care until officers and directors are properly trained about occupational health and safety and their personal liabilities, supervisors are trained to handle the day-to-day business of health and safety, and JHSCs are properly trained to monitor it all and make useful recommendations. In this sector in particular, where health and safety is decades behind, there needs to be widespread certification training such as occurred at Timmins District Hospital, which certified all of their management (*see above*). At the very least, all JHSC members should be certified.

Recommendations

33. Safe Work Associations, using the Workers' Health and Safety Centre (WHSC) model for certification, work collaboratively to develop standard curricula, standards for training, delivery of training, and monitor compliance with set standards.
34. Legislation should be amended to require certification training for all directors, officers and all JHSC members.

35. Amend training in corporate governance schools to include training on occupational health and safety and personal liability.
36. From 1991 to 1995, the now defunct Workplace Health and Safety Agency developed criteria to establish which workplaces required a one-, two- or three-week Certification training course, based on payroll and number and type of hazards in the workplace. Legislation should be enacted to reinstitute this requirement.
37. Enact recommendations in ONA's submission, dated February 1, 2010 and sent to the WSIB, regarding Joint Health and Safety Committee Certification Program Consultation Paper (*see Appendix A – Tab 13*).
7. Should a worker health and safety representative be required at every workplace where a JHSC is not required?

Not only should worker safety representatives be required at these workplaces, but they should, as discussed above, be required in addition to JHSC members in units throughout the workplace (*see above*).

8. What impediments or barriers are there which may prevent a worker from participating within the internal responsibility system to identify and resolve health and safety concerns?

The internal responsibility system (IRS) is not popular with the labour movement because it is not working. But nowhere is it more dysfunctional (if it even exists) than in the high-risk health care sector. The organizational culture described earlier in the submission, and corroborated by Justice Campbell, is not open to occupational health and safety ideas or worker input. During SARS, we heard reports that workers were discouraged from wearing respirators because they would frighten patients. The consequences of this attitude were tragic. Yet, during the recent H1N1 outbreak, we were exposed to the same attitude from senior health care sector leaders. As discussed earlier, the province's chief medical officer of health reportedly discouraged the use of respirators for similar reasons (*see Appendix A – Tab 5*). A medical officer of health reportedly told a worker that she could have a respirator if she 'was paranoid enough' to want one.

Leaders in this sector and directors and officers of employer organizations are not trained in occupational health and safety law, principles and liabilities. Neither are supervisors. Physicians flout occupational health and safety law. Virtually no one is held personally accountable. As discussed in the enforcement section, we are aware of only one set of personal orders issued to individuals, and of only one prosecution against an individual in this sector.

Of course in such an environment, workers are reluctant to step forward and identify health and safety concerns. Fear of reprisal is very real in this sector.

9. What can the government do to strengthen the internal responsibility system and ensure that all workplace parties are able to play a meaningful role in the internal responsibility system?

The discussions and recommendations throughout the submission cover four main areas that could strengthen the IRS. The government needs to:

- Lead by example; e.g. the highest levels of the MOHLTC should publicly commit to occupational health and safety law and principles and use a variety of tools to ensure top-down education and personal accountability in the ministry and throughout the sector;
 - Broaden enforcement, consolidate preventive and reactive enforcement in the MOL and direct and empower inspectors to more easily enforce top-down accountability for occupational health and safety;
 - Make legislative amendments and enhancements to expand the powers of the JHSC and address reprisals;
 - Establish and enforce training standards and broaden the reach of training from school to regulatory colleges, and government and workplace leaders, supervisors, workers and JHSCs.
10. Is the reprisal protection currently provided sufficient to protect workers who raise health and safety concerns or exercise their rights under the legislation?

No. Too few workplace parties are aware of the “protection” and workers or their representatives must initiate the action. It would be better to avoid the opportunity for reprisal in the first place, by establishing unit health and safety representatives through whom concerns can be reported to supervisors/employers.

If a reprisal occurs, workers are subject to the added stress of carrying the complaint through to the Board. It would be easier on workers to have inspectors respond to reprisals. Such a response should have a more immediate specific and general deterrence effect than the current system.

11. What role should the various partners play in promoting a robust and functional internal responsibility system in Ontario workplaces?

See section on “Partners”, page 14.

Technology/Innovation

Questions:

1. Do you have examples of how information or manufacturing technology has significantly improved health and safety in your workplace and how advances in technology can be extended to workplaces with limited or no access to them?

The MOL Consultation paper cites material-handling robots as a manufacturing innovation which is contemplated for discussion in this section.

Health care examples:

- According to the Ontario Safety Association for Community and Healthcare (OSACH), 54 per cent of injuries recorded in health care in 2007 were classified as musculoskeletal disorders – 24 per cent from client handling, 30 per cent from other sources.²⁷ In 2005-2006, the MOHLTC released funding to health care facilities for patient-lifting devices (see *Appendix A – Tab 14*).

- The government also enacted legislation to phase in mandatory use of safety-engineered medical devices (SEMDs) to prevent injuries from hollow-bore needles. That requirement commenced in hospitals and other facilities in 2007, with the final phase for doctors' offices and others effective July 1, 2010.

Some employers voluntarily instituted mechanical patient lifts, and some used SEMDs for some purposes, but it took proactive government action in the form of funding (for lifts) and legislation (for SEMDs) before these innovations were extended uniformly across all workplaces in the sector. Toronto East General Hospital (TEGH) advised our health and safety specialist that they experienced a greater than 90-per-cent reduction in needlestick injuries after implementing safety-engineered devices.

2. Have you encountered situations where introducing a new technology created potential health and safety hazards? What did you do to identify and control/eliminate these hazards? What steps could have been taken at the onset to prevent the hazards from occurring?

Widespread introduction of lifts was not without problems. We received reports from members that workers were not always consulted before installation. In some cases, they actually became hindrances – for instance, patient curtains interfered with their operation. Training was not always given and workers reported not always knowing how to use them and often not using them at all. We heard that they were installed in some areas but had to be removed when units moved as the hospital was renovated. Removal of ceiling lifts was reportedly expensive. At a September, 2007 Region 1 ONA Network Teleconference, we also heard of a problem at Fairvern Nursing Home when a lift was not properly installed into the ceiling and collapsed when workers used it for the first transfer of a heavy patient. A serious accident reportedly occurred when a portable lift malfunctioned while transferring a patient. A health care aid was reportedly seriously injured.

The *Regulation for Health Care and Residential Establishments* does not contain provisions similar to that in the *Regulation for Industrial Establishments* requiring pre-start health and safety reviews (section 7), nor pre-start and subsequent regular inspections and operation of lifting devices only by trained workers (section 51). One can only wonder

why standards of safety in one sector are not applicable to another. Applying industrial lifting-device standards to patient-lifting devices may avert accidents. In 2006, ONA directed members to rely on the external responsibility system (call the MOL) if information and training with respect to patient lifts was not forthcoming from employers.

In the spring of 2003, problems were discovered with the installation of new anesthetic gas machines at North Bay's Hospital; later that year, there were elevated levels of nitrous oxide detected. The hospital was prosecuted and convicted on one count. Would pre-start review legislation have averted that problem?

It is our understanding that in industrial settings like General Motors, Ford and Chrysler, union health and safety representatives have the right to approve or reject new equipment.²⁸

ONA guides its members to rely on the external responsibility system and call the MOL when we encounter such problems. However, pre-start reviews that are legislated elsewhere, or legislated inspection standards or arrangements for consultation/approval by worker experts such as exist in industry, may have prevented these hazards from existing. And, as recommended earlier in this submission, ministries and employers must require occupational health and safety filters before approving funding, contracts, purchasing, etc.

3. What measures can be taken at the pre-design or design stage to eliminate hazards? Are you aware of any methods used in other jurisdictions to identify and control hazards before introducing a new process or changing an existing one?

See above. As well, increasing research is suggesting that proper design of buildings and units with infection control and health and safety in mind can prevent hazards such as spread of infection. In one study, "researchers argue that although it's expensive to build facilities with many private rooms, it's still cheaper in the long run because it can cost as much as \$30,000 to treat a patient with a stubborn, drug-resistant and hospital-acquired superbug."²⁹

It is particularly important that health care facilities filter facility and equipment design and plans through an occupational health and safety lens prior to procurement. Yet this seems to be a new concept in health care. In 2004, then Minister of Health and Long-Term Care George Smitherman addressed a group after touring the new hospital in Thunder Bay. He candidly expressed his surprise that this brand-new facility had not been outfitted with patient lifts. We receive reports of health and safety measures that are removed from health care facility designs because of cost. In one instance, planned automatic doors were eliminated during building, until a worker sustained a serious and expensive injury, after which the doors were reportedly retroactively made automatic at greater expense than if they had been installed as originally planned. In one of our large health care facilities the design team regularly attended JHSC meetings to provide ongoing reports and receive H&S feedback for the protection of workers. JHSC members also conducted site inspections of the new project. In addition, a mock-up room of the new design was created so staff could enter and provide health and safety feedback for constant improvement.

4. What barriers have you experienced in implementing new technology to improve health and safety?

Some barriers have been described above. Also, though the MOHLTC provided money for patient-lifting devices, that was one-time funding. Health and safety measures face barriers when there is no sustained funding and budgeting for their continuation. Lack of proper funding also affects our home care workers who have told us service providers accept contracts from the Community Care Access Centre (CCAC) without proper consideration of devices that could safely assist the worker in providing care to the patient. Our members have told us if their service provider were to turn down contracts because of a lack of devices that could protect workers' health and safety, they would soon be out of business as the CCAC will simply award the contract to another provider.

With respect to the institution of SEMDs in the workplace, the peculiar environment (described earlier) that seemingly allows special treatment of physicians has presented a barrier in some facilities as some surgeons and others have refused to use them.

5. What electronic data and information collected by the various OHS system partners should be shared among the occupational health and safety system partners and the public?

Any data that could indicate poor performance should be considered. For instance, after a serious injury/fatality is known to WSIB, this information should then be shared with the MOL to ensure immediate follow up, employers who are caught by WSIB violating claims or revenue requirements under the WSIA; employers who have poor records under other regulatory regimes which may indicate careless health and safety practices and violations – for example, employment standards, infectious disease control – reports to public health about outbreaks, environmental offences and issues with the Canada Revenue Agency. Safe Work Associations may also access “near miss” data when intervening at a workplace and this information should be shared with all partners, as it would be valuable in preventing injuries before they happen. First-aid records from a workplace should be reviewed and considered for targeted interventions and enforcement. Workwell Audits and prosecutions should also be shared with the partners and the public.

6. How can government policy and regulations assist in the use of new technology to improve health and safety?

As emphasized throughout this submission, government needs to lead by example. Earlier recommendations about integrating enforceable health and safety provisions into accountability agreements, physician privileges agreements, performance standards, service and equipment contracts, apply here.

Recommendations:

38. Transport legislated industrial standards such as pre-start reviews, lifting device inspections and others appropriate to the health care sector either by amending the *Regulation for Health Care and Residential Facilities* to include, or by amending the *Regulation for Industrial Establishments* to extend to all workplaces.
39. Government should provide sustained funding for health and safety initiatives and employers should establish health and safety lines in their budgets.

40. Government should make funding of health care and other workplaces dependent on the application of occupational health and safety/infection control filters, including the consultation of the JHSC and workers, as noted in this submission, to design the elimination of hazards before construction or procurement of equipment, etc.
41. Government should have one business number assigned for each employer and all information as noted above should be entered into a common database; information pertaining to that business should be shared and cross-checked with all system partners for prevention and enforcement activities.

Training

Questions

1. Are there training principles and methods that are key elements of effectively imparting health and safety knowledge to workers?

ONA believes it is important to apply adult education theory and methods when training the workforce. This approach includes cycles of providing experience, reflection on that experience (reactions, thoughts, feelings), generalization (drawing conclusions from the experience and discussion), application of the knowledge (how are they used/apply what they learned back home) and then evaluating the learning/transfer of knowledge.

Evaluation in itself is a whole strategy that assesses the transfer of learning through identified measures in the classroom, back in the workplace at, for instance, six, 12 and 24 months out. The application of this theory and methods is independent of the topic/subject matter.

ONA is a firm proponent and practitioner of continuous learning, a principle which is important for occupational health and safety. As explained elsewhere, health care workplaces in particular are complex, dynamic environments containing “common” and more “exotic” hazards and constant change. To protect workers against existing, changing and new hazards in the workplace, the employer must ensure that training is developed

and delivered in consultation with the JHSC, then re-enforced, and retaught as necessary (e.g. when there are changes in the workplace or when workers move about the workplace).

The WHMIS and respiratory protection training requirements provide helpful examples upon which to base all health and safety training. One-time delivery is insufficient. Reviews and repeat delivery are important to keep knowledge base current and understanding of hazards and protections fresh.

2. Should there be mandatory entry-level training for workers, supervisors and managers? Should the curriculum and method of training be prescribed?

As discussed and recommended throughout the submission, if we are ever to achieve a true occupational health and safety culture in our sector (automatically implicating patient safety), where everyone trusts that their health and safety is a key value of the organization, then top-down understanding, commitment and passion about health and safety must rain down on the sector from its very heights. We have pointed out numerous examples of the past and current dearth of occupational health and safety knowledge in health care leadership. For that reason, solid training about occupational health and safety law, principles and personal liabilities must be made mandatory for all leaders of the sector, from top MOHLTC officials downward (including Local Health Integration Networks [LHINs]) to employer officers, directors, supervisors, workers and Joint Health and Safety Committee members. The LHINs should ensure that each hospital's accountability agreement includes training requirements, as noted above.

Within such a construct of knowledge, understanding and commitment, workers will know that their health and safety (indivisible from patient safety) matters in their workplace. Workers themselves, in accordance with occupational health and safety law and principles, must also be trained about the hazards of their work, protections and legal rights and responsibilities. This training should begin in high schools, flow through post-secondary institutions and thereafter form a substantial piece of orientation and continuous learning in the workplace. In accordance with the provisions of the *Regulation*

for Health Care and Residential Facilities, training and education must be developed and delivered in consultation with the JHSC.

Our members tell us that there is no consistency in the training curricula and delivery in our workplaces. Employers hire a myriad of providers, who provide a variety of programs of varying content, duration and value. They are making a strong plea for establishing training standards. It would be difficult to prescribe the exact standards, but the SWAs could work collaboratively to develop standards that employers, in consultation with JHSCs, could adapt to their individual workplace needs. SWAs, supported by MOL enforcement where appropriate, could monitor compliance with standards. It should also be noted for many workplaces, employers develop their own methods of “training” which quite often amount to mere communication of policies. At London Health Sciences Centre, after the death of a member exposed to *Methicillin-resistant Staphylococcus aureus* (MRSA), the JHSC found that training was deficient and often amounted to only communicating policies and standards on the employer’s intranet versus any real hands-on training. After the death of our member, the employer engaged in hands-on training, i.e. donning and doffing of personal protective equipment for a specific group of workers. Our ONA representative in London tells us that in areas where hands-on training has occurred and when staff is given the opportunity to demonstrate what they have learned, the retention of information is higher, as demonstrated by a recent MOL visit to the emergency department. However, she expressed frustration that hands-on training has not been adopted on a facility-wide basis. Essentially, coordinators not involved in the program most affected by the loss of our nurse continue to just e-mail or provide, for example, laminated cards on donning and doffing, so best practice is not addressed by the organization as a whole.

We understand that construction project trades people receive solid occupational health and safety orientation specific to each new site they are to enter before being allowed on site. An ONA leader visiting the new North Bay Hospital construction project was impressed with the solid health and safety orientation she received before being able to enter that project. When touring the site, she felt that health and safety considerations were second nature at this workplace. She expressed a hope that one day such health

and safety consciousness could be captured and translated to the health care work sector.

3. Are there criteria that should guide decisions on when a specific training program should be mandatory?

From 1991 to 1995, the now defunct Workplace Health and Safety Agency developed criteria to establish which workplaces required a one-, two- or three-week Certification training course, based on payroll and number and type of hazards in the workplace. Legislation should be enacted to reinstitute this requirement, which would have particular application to our high-risk workplaces.

As recommended earlier in this submission, as a baseline, senior officials of the MOHLTC (including LHINs), directors, officers, supervisors and JHSC members of health care employers should at least receive certification training and occupational law, principles and liability should also be taught at any corporate governance school.

Of course, sector-specific training must continue. The law and the concept of the IRS, hazard identification, risk/hazard assessment, etc. are common to all sectors. But workers must continue to receive additional training about risks inherent in their own workplaces, e.g., anesthetic gases in health care, rock bursts at a mine site, etc.

4. Do you have an example of a highly effective training program that you could describe?

The Basic Certification training delivered by the Workers Health and Safety Centre is an excellent program with solid content and knowledgeable instructors who have a wealth of experience in health and safety in diverse workplaces. We have received very positive feedback from members who have participated in this course.

5. When providing health and safety information, instruction and training to workers, how do you take into account: (1) literacy levels, in any language; and (2) the presence of multiple languages at the workplace?

ONA workshops aim for grade 5/6 level of education. We do not provide education in other languages. All our materials are in English

2. How have you incorporated visual aids (e.g., pictures, symbols, demonstrations, etc.) into health and safety training?

ONA workshops include a variety of activities to appeal to all four types of learning styles and that is why we include a variety of methods: reading articles, small and large group discussion, review of case studies, video, power point presentation, role plays and lecturettes.

ENFORCEMENT BACKGROUND AND CONTEXT

Rely on the Internal Responsibility System?

In his 1976 *Ham Commission Report*, Dr. James Ham introduced an occupational health and safety Internal Responsibility System (IRS) which has since become the implicit framework around which all modern Canadian occupational health and safety legislation is built.

But despite the fact that Ontario's *Occupational Health and Safety Act (OHSA)* (with its implicit IRS) has explicitly applied to health care sector employers for more than three decades, in the 2007 *SARS Commission Report*, the late Justice Archie Campbell confirmed the dismal state of occupational health and safety in our workplaces. While ONA endorses efforts to establish an effective IRS in each workplace and we know an IRS does not develop overnight, after three decades, the vast majority of workplaces in the health care sector do not have anything resembling a mature IRS. At the April, 2004 Ministry of Labour Health Care Health and Safety Action Group, one employer representative who originally came from industry and who headed the occupational health and safety department of a large teaching hospital, said that when he entered the health care sector, he felt like he had taken a step back in time. He advised the meeting that he felt that hospitals' health and safety practices were the way they were in industry 20 years ago. We have heard similar comments from industry transplants in other health care facilities around the province. This is unacceptable. More needs to be done.

The External Responsibility System

The Ontario government commissioned an independent review of the MOL health and safety division in the 1980s. The *Mackenzie Laskin* study looked at the Internal Responsibility System then and found that one of the things a successful IRS needs is:

- *Consistent enforcement of the Act and meaningful penalties for those who violate the rules.*³⁰

ONA believes that the “external responsibility system” of enforcement (primarily by MOL inspections, orders and prosecutions), bolstered by other “enforcement” tools, must be used to stimulate a sluggish IRS and motivate workplace parties to work together to establish safe and healthy workplaces.

Until the workplace IRS is at the “ethical compliance” level (and few if any workplaces realistically reach this pinnacle), workers must continue to rely on the “external responsibility system” of enforced compliance with occupational health and safety and other law and enforcement tools.

THE TASK OF ENFORCEMENT

ONA takes a broad view of enforcement for occupational health and safety purposes. Many standards, legislated and otherwise, are designed to make workplaces safe and healthy and many players are currently involved in “enforcing” those standards.

What standards/rules should be “enforced”?

- Legislation:
 - The *Occupational Health and Safety Act (OHSA)* and its regulations are the primary provincial statutes establishing health and safety standards in workplaces. Others, such as the *Building Code Act*, the *Fire Protection and Prevention Act*, etc. will not be discussed here;
 - In 2004, the negligence sections of the *Criminal Code of Canada* were built on to make it easier to prosecute for workplace safety crimes (popularly referred to as the *Westray sections*).

- Many collective agreements contain occupational health and safety provisions, e.g. ONA Hospital Central Agreement.
- Performance contracts for directors and officers of corporations.
- Work contracts.
- Audit program standards (e.g. Workwell audit, CSA occupational health and safety management system standards, etc.).
- Accreditation standards (e.g. Hospital accreditation).

Who should enforce? With which tools?

The Internal Responsibility System, though perhaps theoretically a helpful instrument conducive to compliance with occupational health and safety law, standards and principles, is not working in Ontario health care sector workplaces. Justice Campbell eloquently described the problems with “worker safety systems.” ONA continues to receive frequent anecdotal information from members confirming that the IRS is not working in health care workplaces, further corroborated by a recent ONA survey (*see Appendix A – Tab 11*).

ONA believes that rather than abandon the IRS, it should be bolstered as a foundation for occupational health and safety “enforcement.” There are simply too many workplaces and too few enforcement officers to leave occupational health and safety compliance measures to external parties. The conclusions of the *Mackenzie Laskin* study mentioned above are still relevant today and suggest some solutions, particularly with respect to a sector of employers who have not embraced occupational health and safety as a priority. In their report, they said:

For the system to be effective, the complete line of command, from the Board of Directors through the chief executive, managers, supervisors and workers, must be accountable for health and safety in the workplace...Support from the top is vital; the chief executive who sets health and safety as an equal and integral part of the management process, along with productivity and cost control, will achieve direct benefits in the form of a better health and safety record, and indirect benefits through improved morale, employee pride in their company and public recognition.

The investigators further commented that a successful IRS needs:

- *Commitment by senior management to provide for meaningful worker participation in health and safety matters;*
- *Access by workers to relevant information on health and safety matters;*
- *Education and training on health and safety for workers and management personnel;*
- *Consistent enforcement of the Act and meaningful penalties for those who violate the rules.³⁰*

Accountability

ONA believes that measures must be taken to make occupational health and safety compliance a personal matter for directors, officers, supervisors and physicians in a workplace.

- ONA staff was told by the CEO of a large hospital that he would establish occupational health and safety as a priority if it was one of his accountabilities in his performance contract.
- At a national conference in 2009, a senior executive of Hotel Dieu-Grace Hospital spoke candidly about the impact of the horrific workplace murder of Lori Dupont, RN. The executive divulged that because of such urgent competing priorities in health care, only a “burning platform” gets priority attention from hospital executives. She said that even after the murder and a police investigation, the employer did not take every precaution reasonable to protect workers until the Ministry of Labour thereafter sent a team of inspectors into the workplace.
- An audience member at the same conference identified himself as a hospital CEO and commented that even at his level of responsibility, he is not able to elevate the profile of occupational health and safety to the priority it deserves. He opined that occupational health and safety issues need to be raised with Boards of Directors to achieve priority status.
- In the last two years, Niagara Health System was surcharged \$1.7 million by the WSIB. As a result, management is working with unions and others to change the culture of safety and develop a safe return to work protocol for injured workers. At a recent meeting, the employer announced that for the first time, their Board of Directors made occupational

health and safety a part of the CEO's performance measures. The CEO subsequently made safety a performance standard for her Vice-President of Human Resources.

- In 2007, North Bay General Hospital was convicted for health and safety violations relating to a 2003 nitrous oxide leak. Costs for defending the hospital and costs for litigating related grievances were reportedly paid with emergency funding from MOHLTC (see *Appendix A – Tab 16*). No individuals were charged nor penalized.
- In 2005, after problems achieving compliance with safe sharps disposal, an inspector at Timmins District Hospital wrote orders naming supervisors. Thereafter, the employer gave supervisors full-day safety training (see *Appendix A – Tab 17*).
- Physicians are granted “privileges” (not “rights”) to practice in Ontario hospitals. It is our understanding that the Hospital for Sick Children revoked privileges for physicians who would not comply with hospital occupational health and safety policies.
- It is our understanding that typically in industry, contractors are made to comply with host employer occupational health and safety policies/procedures or forfeit their contract and jeopardize future opportunities for work.

Recommendations:

42. Promote the inclusion of enforceable occupational health and safety requirements in director and officer accountability agreements, physician privilege agreements and contracts for work by contractors. For the purposes of enforcement of the general duties section of the *Occupational Health and Safety Act (OHSA)*, consider these provisions and their enforcement as ‘reasonable precautions’ for employers to take and issue orders for compliance. Insert this approach in the Ministry of Labour policy and procedures manual for inspectors.
43. Educate and direct inspectors to issue personal orders and initiate personal prosecutions against individual officers and directors to gain their personal attention, especially in health care, a difficult environment with serious competing priorities. Expand the schedule offences for ticketable offences to include health care employers and supervisors for particular offences.

44. Direct inspectors to consider occupational health and safety provisions of collective agreements as “reasonable precautions” to protect workers, and to issue orders under the general duties clause of the *OHS*A when such provisions are violated. Insert this approach in the Ministry of Labour policy and procedures manual for inspectors.

Strengthen JHSC power to monitor, achieve compliance

The original draft of the *OHS*A proposed greater power for JHSC members. The power to unilaterally stop unsafe work was originally contemplated for specified trained JHSC members. Other jurisdictions have legislated provisions which establish stronger committees with the resources and some power to achieve compliance with health and safety standards.

Northern European legislation provides for majority membership for workers on safety committees, roving worker health and safety representatives, appointed and trained by unions with the power to inspect small workplaces, speak with the workers and express their concerns to the employer.

Worker health and safety representatives in Victoria and Queensland, Australia are empowered to write Provisional Improvement Notices which act as posted orders to the employer for health and safety violations, and stop unsafe work.

Recommendations:

45. Increase worker representation on JHSCs.
46. Empower worker safety representatives to issue enforceable orders against employers who have control of the workplace.
47. Empower trained health and safety representatives to unilaterally stop work when necessary.

Reactive/Preventive Enforcement

Law enforcement agencies typically combine a number of approaches to securing compliance with legislation. Police forces react and respond to complaints and incidents, but also engage in intelligence gathering, research, analysis and trending to develop prevention programs and initiatives and deliver prevention messaging to the public. Enforcement combines reactive and prevention efforts in one agency. It would be hard to imagine a police force divesting itself of responsibility for crime prevention.

On the other hand, health and safety enforcement and prevention have been segregated in Ontario. In 1998, our compensation legislation was revised to transfer the responsibility for promotion of health and safety and prevention of workplace injuries and disease to the Workplace Safety and Insurance Board. The Board has had 13 years to make progress in this area but has failed miserably on several fronts:

Questionable intelligence

Genuine prevention measures must be based on accurate statistics which honestly depict the state of health and safety in a workplace. There is much evidence that the WSIB is most interested in curbing costs of claims it must finance. Reporting requirements in the *Workplace Safety and Insurance Act* and attendant policies have a different purpose and paint a different picture than the reporting requirements in the notice provisions of the *Occupational Health and Safety Act*. Evaluation of occupational health and safety is complex. Bird's triangle theory about the relationship between the number of "near misses" and the statistical predictability of critical incidents demonstrates the value of considering all incidents, whether they result in "serious" injury or not.³¹ Ignore a "near miss" and you neglect an opportunity to prevent a future accident.

The International Labour Office corroborated the complexity of occupational health and safety evaluation when it outlined the elements for performance monitoring and measurement. It says you need:

*both qualitative and quantitative measures appropriate to the needs of the organization...andinclude both active and reactive monitoring, and **not be based only upon work-related injury, ill health, disease and incident statistics.***

The complexity of evaluation is illustrated by this more complete excerpt from the International Labour Organization guidelines:

3.11. Performance monitoring and measurement

3.11.1. Procedures to monitor, measure and record OSH performance on a regular basis should be developed, established and periodically reviewed. Responsibility, accountability and authority for monitoring at different levels in the management structure should be allocated.

3.11.2. The selection of performance indicators should be according to the size and nature of activity of the organization and the OSH objectives.

Evaluation

3.11.3. Both qualitative and quantitative measures appropriate to the needs of the organization should be considered. These should:

(a) be based on the organization's identified hazards and risks, the commitments in the OSH policy and the OSH objectives; and

(b) support the organization's evaluation process, including the management review.

3.11.4. Performance monitoring and measurement should:

(a) be used as a means of determining the extent to which OSH policy and objectives are being implemented and risks are controlled;

(b) include both active and reactive monitoring, and not be based only upon work-related injury, ill health, disease and incident statistics; and

(c) be recorded.

3.11.5. Monitoring should provide:

(a) feedback on OSH performance;

(b) information to determine whether the day-to-day arrangements for hazard and risk identification, prevention and control are in place and operating effectively; and

(c) the basis for decisions about improvement in hazard identification and risk control, and the OSH management system.

3.11.6. *Active monitoring should contain the elements necessary to have a proactive system and should include:*

(a) monitoring of the achievement of specific plans, established performance criteria and objectives;

(b) the systematic inspection of work systems, premises, plant and equipment;

(c) surveillance of the working environment, including work organization;

(d) surveillance of workers' health, where appropriate, through suitable medical monitoring or follow-up of workers for early detection of signs and symptoms of harm to health in order to determine the effectiveness of prevention and control measures; and

(e) compliance with applicable national laws and regulations, collective agreements and other commitments on OSH to which the organization subscribes.

3.11.7. *Reactive monitoring should include the identification, reporting and investigation of:*

(a) work-related injuries, ill health (including monitoring of aggregate sickness absence records), diseases and incidents;

(b) other losses, such as damage to property;

(c) deficient safety and health performance, and OSH management system failures; and

(d) workers' rehabilitation and health-restoration programmes.³²

WSIB prevention efforts start from a false premise. As explained earlier, WSIB's prevention, incentive and penalties exclude quantity of injuries. Yet every injury, despite its duration or cost, arises from a hazard.

You cannot have effective enforcement in the form of preventive programs and initiatives if you do not even strive to honestly evaluate the problem. Police forces arguably strive for order and justice. If their statistics ignored assaults that did not have particular dollar amounts, would their prevention efforts be effective?

Failure to understand occupational health and safety and failure to lead

Although 13 years ago, WSIB was charged with promoting health and safety and preventing injury and disease, WSIB officials told ONA staff in July, 2006 that they never taught occupational health and safety law and principles to their own staff and their decision makers

were never taught the law and principles with respect to evidence. Numerous ONA members have been reinjured as decision makers failed to properly weigh relevant and material evidence and apply occupational health and safety law and principles (see *Appendix A – Tab 8*). ONA and the OFL brought this to the Board’s attention in a series of meetings in 2006, and after 14 drafts, WSIB finally agreed to a principles document to be piloted in a workplace with a solid IRS (see *Appendix A – Tab 4*). The health and safety savvy workplace parties selected to pilot this project described the document, which took WSIB five years and 14 drafts to accept, as “pretty basic.” WSIB, “leaders” in prevention, still have not launched this project.

Recommendations:

48. Take prevention responsibility from the WSIB, and leave the Board to manage compensation claims.
49. Move prevention to the MOL so that reactive and preventive enforcement initiatives and programs:
 - a. can be developed with the common goal of achieving safe and healthy workplaces;
 - b. can be developed based on comprehensive qualitative and quantitative measures;
 - c. can consider injury data based on the reporting requirements of the *OHSA*, capturing all lost-time injuries of limited or extended duration and “near misses” in all workplaces, not just those identified in section 53 of the *OHSA*.
50. WSIB to operationalize draft 14 of the occupational health and safety principles document negotiated with the OFL (see *Appendix A – Tab 4*), teach decision makers occupational health and safety law and principles and require them to factor them into their adjudication.
51. WSIB to teach decision-makers the laws and principles governing evidence so that they can safely adjudicate claims and prevent further reinjuries of vulnerable workers.
52. Workwell audits or a version should be moved to the MOL; as one tool for prevention, MOL inspectors should be empowered to order them as a “precaution reasonable” under the general duties’ clause.

Ministry of Labour Enforcement

ONA and OPSEU jointly made a number of recommendations to the SARS Commission about the need to establish focused resources in the health care sector similar to the focus that the ministry has historically applied to the mining and construction sectors. Before SARS, little enforcement attention was paid to health care employers, relatively few orders were issued, and we knew of only one health care prosecution in the 25 years that the legislation was in effect in the sector. SARS was a health and safety consciousness-raising event; we have since noted considerable progress with MOL enforcement in our workplaces. Numerous blitzes have occurred, thousands of orders have been issued and there have been several prosecutions with resulting convictions. We have received anecdotal evidence from members of the value of having inspectors with a health care background and expertise and the value of specific and general deterrence effects of these efforts. Through union networks of activists, members share information about orders and prosecutions and employers have reportedly exhibited concern. For instance, though unions made many attempts to work with the Centre for Addiction and Mental Health to reduce the risk of violence, it was not until the facility was convicted and fined that the employer agreed to work collaboratively to stem the incidents of violence there.

There are discernible challenges: ONA members have expressed that they generally have very good relations with enforcement agencies, but we have encountered confusion among the agencies. In an instance in 2005 in northern Ontario, when there was evidence that a hospital supervisor was a threat to her subordinates and herself, the MOL advised us it was not a health and safety issue. At the same hospital, following many issues including six incidents of overhead demolition debris (during reconstruction of the hospital) including pipes and bolts, crashing through ceiling tiles to active areas where there were workers and patients, we resorted to writing to the Minister for enforcement action (*see Appendix A – Tab 15*). Conversely, we have had some difficulty getting police officers to address violence issues in our workplaces; once, when refusing to take enforcement action, an officer even expressed aloud that a violent attack was just “part of the job” for health care workers. Sometimes we have had MOL inspectors suggest that assaults in the workplace are police matters, and police have dismissed them as regular job hazards, leaving our member feeling unprotected by the law and

its enforcement agents. Again, our President wrote government ministers asking for action (see *Appendix A – Tab 6*).

Our members' most serious injuries (fatalities) arise from motor vehicle accidents during the course of work. Given the pressures and short staffing in the health care sector, workplace factors may be at play, but police forces are not trained to understand or apply occupational health and safety law and principles during their investigations. The MOL should also investigate workplace-related motor vehicle accidents.

Recommendations:

53. MOL continue its health care focus, enforcement initiatives and prosecution in the health care sector.
54. MOL investigate workplace-related motor vehicle injuries for workplace-related root causes and appropriate enforcement responses.
55. MOL issue orders under the general duties' section of the *OHSA* for increased staff when investigation reveals that insufficient staff creates a risk in the workplace.

Criminal Code of Canada Enforcement and Enforcement Agency Collaboration

We have been told by officers and others that police are not trained to understand nor apply either the *OHSA* or the “Westray” provisions of the *CCC*.

We understand that the MOL and police agencies collaborate during fatalities in mines and construction projects. But we do not see enough evidence of this in health care facilities, as illustrated above. ONA was recently advised by a central Ontario health and safety leader that police automatically called the MOL after responding to an incident in a long-term care facility. The MOL attended to probe the occupational health and safety aspects of the incident. ONA hopes that this is the beginning of a trend.

Recommendation:

56. Educate police officers about occupational health and safety law and the functions of the MOL and about health and safety amendments to the negligence sections of the CCC. Direct police to apply this law, where appropriate. Develop and apply protocols for collaborating and/or communicating when work-related accidents/incidents occur.

Enforcement Coverage for All Health Care Workers

Our members tell of some confusion with respect to protections for them in workplaces where the *Regulation for Healthcare and Residential Facilities* does not apply, e.g. health units, clinics, community nursing. Our members in all of these workplaces face similar risks as do those covered by this regulation.

Recommendation:

57. Extend coverage of the Regulation for Healthcare and Residential Facilities to all workplaces within which health care workers work.

The Precautionary Principle

Justice Campbell's number-one "take-home" message was to use the precautionary principle – that action to reduce risk need not await complete certainty. We hope that we have painted a credible picture of the serious risks health care worker face daily as they struggle to provide care to Ontarians. It is here in our workplaces, which are decades behind in health and safety practice, and where so much is at stake, that our members paid the ultimate price that underscored the need for the precautionary principle in occupational health and safety. Health care has never considered itself dangerous like "mines and factories," but it is. Until the Campbell Commission report, there was little attention to enforcement in this sector. It is only fitting that we use Justice Campbell's wisdom to conclude our submission:

Recommendation:

58. "That the precautionary principle, which states that action to reduce risk need not await scientific certainty, be expressly adopted as a guiding principle throughout Ontario's

health, public health and worker safety systems by way of policy statement, by explicit reference in all relevant operational standards and directions, and by way of inclusion, through preamble, statement of principle, or otherwise, in the *Occupational Health and Safety Act*, the *Health Protection and Promotions Act*, and all relevant health statutes and regulations.

15. Institute for Work & Health. *Annual Report 2005: Protecting the Health Of Healthcare Workers*
http://www.iwh.on.ca/archive/pdfs/IWH_ar2005.pdf (accessed October 21, 2008).
16. Ontario Workplace Safety and Insurance Board, *op.cit.*, p. 12.
17. Nadarajah, Ramani, "Environmental Penalties: New Enforcement Tool or the Demise of Environmental Prosecutions" published in *Environmental Law – A Year in Review, 2007* by Stan Berger and Dianne Saxe
18. *Spring of Fear*, executive summary, page 17
19. *Spring of Fear*, executive summary, page 18
20. M. Kerr, "Can an Expanded and Integrated Occupational Health Service Help Buffer the Impact of a Global Influenza Outbreak in Healthcare Organizations?"
21. *Healthcare Papers New Models for the New Healthcare* 8(1): 2007, p. 36.
22. Yassi, Annalee and Hancock, Tina *Patient Safety – Worker Safety: Building a Culture of Safety to Improve Healthcare Worker and Patient Well-Being, Healthcare Quarterly*, October 2005
23. Garner, Charlotte A., *How Smart Managers Create World-Class Safety, Health, and Environmental Programs*, 2004 American Society of Safety Engineers, pp. 201, 202

Incentives Endnotes

24. *Guidelines on occupational safety and health management systems* ILO-OSH 2001 International Labour Office-Geneva
25. Roughton, James E., Mercurio, James J., *Developing an Effective Safety Culture, A Leadership Approach*, Butterworth-Heinemann 2002, pp. xxxiv-xxxv1

JHSC Endnotes

26. *Spring of Fear*, executive summary, page 55

Technology Endnotes

27. Sikorski, Joseline *Connecting Worker Safety To Patient Safety: A New Imperative For Health-Care Leaders*, *Ivey Business Journal*, January/February 2009
28. Walker, Cathy "IRS: Success or Failure? A Union Perspective" Presentation to CCOHS *Leading Workplace Change Conference* March 8, 2010
29. *Sharing Hospital Room Increases Risk of Infection*, January 5, 2010 CTV report on study led by Dr. Dick Zoutman.

Enforcement Endnotes

30. *Occupational Health and Safety: A Guide for ONA Members*, page 7
31. Heinrich, Bird, Fletcher and others have demonstrated a statistical ratio between “serious” and “minor” incidents. For instance, Bird suggested every serious injury would be preceded by 10 minor injuries, 30 property damage incidents, and 600 other accidents with no injury or damage. (page 222, *Occupational Health: Risk Assessment and Management* Steven S. Sadhra, Krishna G. Rampal)
32. *Guidelines on occupational safety and health management systems*, ILO-OSH 2001 International Labour Organization-Geneva.