

ONTARIO NURSES' ASSOCIATION

Submission to the Ministry of Labour to Review Prevention Programs in Ontario

February 5, 2015



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EXECUTIVE SUMMARY

Introduction

The Ontario Nurses' Association (ONA) is the union representing 60,000 front-line registered nurses and allied health professionals and more than 14,000 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

ONA believes it is the right of all its members to work in a healthy and safe work environment. We further believe 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.

Prevention Programs in Ontario

ONA is pleased to provide this submission into the review of the prevention programs for the Health and Safety System for Ontario. Our view is that for the system to perform as intended, transparent regular reviews and consultation with all of the stakeholders is absolutely necessary.

The lack of/limited worker involvement and participation in all of the current, incentive based programs, more specifically the Safety Groups Program is one of the major shortcomings.

ONA supports the Workers Health and Safety Centre (WHSC) principles of worker-centered programs with a hazard-based approach to the elimination of workplace injuries, illnesses and death. We submit that any framework for prevention programs would be guided by these principles and would be the most effective way for the Ministry of Labour (MOL) to meet its mandate in accordance with Section 4.1(2) of the *Occupational Health and Safety Act (OHSA)*.

Existing Programs in the Occupational Health and Safety System

The Workwell program is one program that had been effective in assisting employers to meet their obligations under the *OSHA*. In our view, this program requires employers to meet the bare minimum of the requirements of Section 25(2)(j) of the *OHSA*. A Workwell audit is a robust evaluation of the employer's health and safety program, and has direct involvement with worker and management members of Joint Health and Safety Committees (JHSCs). The audit itself was a valuable training exercise for JHSC members to learn the requirements of a health and safety program. Workwell, however, is now a voluntary program with no financial penalties for not passing the audit.

Often due to poor Workplace Safety and Insurance Board (WSIB) claims experience, employers were essentially compelled to comply with the law or suffer financial penalties. In other words, employers were not provided financial incentives for mere compliance, they were financially penalized for failing to meet standards after being provided the opportunity to meet compliance.

Moving forward, an enhanced program similar or in addition to a Workwell audit should be used by the prevention system to evaluate workplace health and safety programs, and these can be started at the JHSC level with the proper framework, standards and training.

Any such program should ensure the focus of an audit is on employer compliance with legislation and not on worker behaviours or discipline. Employers have ultimate responsibility for health and safety in the workplace and therefore any audit must assess if the employer's

prevention program is robust enough if implemented to actually protect workers. The Chief Prevention Officer (CPO) has the authority to establish standards for training programs under Section 7.1(1) of the *OSHA*.

The Workwell audit is a measurable audit of a workplace health and safety prevention program. It is also within the mandate of the CPO to establish a standard for the training of JHSCs and Health and Safety Representatives (HSRs) for them to measure their employer's safety and prevention program.

Currently there is no standard or framework for JHSCs/HSRs to use, nor compel their employer to provide appropriate training that teaches the JHSC/HSR how to audit their own program. Once management and worker members of the JHSC or HSR are properly and adequately equipped to evaluate the employers program, the JHSC/HSR can then fulfill its function.

Based on ONA's experiences of the workplaces we represent, the Safety Groups Program does not provide value to the health and safety of Ontario workplaces. The Ontario Hospital Association (OHA) Safety Group received in excess of \$4 million in WSIB rebates in 2013 with no transparent results of what this group accomplished that prevented injury and illness. The difficulty with this program is that any meetings, training and knowledge transfer associated with this group is only shared with management. For this program to be effective, labour representatives should also be permitted to participate and have input into the selection of any safety group priorities. Furthermore, worker members of the JHSCs should be included in the consultation of any measure or procedure being developed as part of the safety group initiatives. However, they are completely excluded and kept in the dark of these notional proactive measures employers are supposedly implementing.

JHSCs should also have full access to all meetings, training and knowledge transfer. Without worker participation, this is simply a non-transparent scheme for employers to receive monetary incentives with no validation or any real change in the workplace that is protecting workers' health and safety.

Employers can receive the financial incentives and still not be in compliance with the *OHSA*. For instance, in 2007 the MOL ordered a Humber River Hospital to provide safety-engineered medical devices (SEMDs) to protect workers (our members) from the hazard of needlestick or sharp injuries. The employer did not immediately comply with the orders and instead chose to appeal the issuance of the orders which could have protected workers. Simultaneously, this employer was participating in a safety group whose initiative that year was SEMDs. The safety groups (including this hospital) as we were told received rebates for achieving their goals despite having at least one employer on the group at that time who was non-compliant with the Occupational Health and Safety Act and fighting the very Ministry of Labour (MOL) orders that could have protected their workers from needlestick/sharp injuries/illnesses. Eventually the employer did implement the orders but only because of extreme lobbying done by the unions to bring public awareness of the employer's actions to keep putting worker safety at risk.

More recently ONA uncovered that the Centre for Addiction and Mental Health (CAMH), in 2013 with over \$263,000 in Workplace Safety and Insurance Board (WSIB) rebates, in fiscal year 2013/2014 alone had over 500 incidents of workplace violence, not to mention other injuries and illnesses, including critical injuries. In fiscal year 2012/2013, 397 violent acts were reported. This means there was a 29 per cent increase in violent incidents over a one-year period and despite this increase and high risk to workers, CAMH still managed to reap a significant experience rating rebate from the WSIB. We can't help but wonder how much additional money this poor performing employer received for merely participating in a safety group and going through the motions.

Consultation Questions

1. Of the prevention programs that are currently available, what aspects do you think are valuable?

Workwell is a valuable measurable program but should be strengthened even further to incorporate the principles outlined by the International Labour Organization (ILO), which corroborated the complexity of occupational health and safety evaluation when it outlined the elements for performance monitoring and measurement.

Prevention programs must also be able to identify hazards and risk, and a great tool that should be a requirement for all employers to use is the new CSA standard (CSA Z1002) on risk assessments, which does not speak about “tolerable” or “acceptable” risk, only effective risk control.

2. What can prevention programs offer to assist workplaces with compliance and awareness of health and safety requirements?

a. Prevention programs can offer training to worker members of the JHSC/HSR to support the internal responsibility system (IRS). The programs require a framework that is transparent and measurable as mentioned above. They could also contain upfront references to fines, penalties, etc. that employer/Boards/Directors/supervisors would be subject to for a number of offences including hiding claims, and violations of the *OHS*A.

3. Do you see gaps or opportunities in the health and safety system where prevention programs could provide compliance assistance, and/or do more outreach to raise awareness of health and safety requirements?

a. One gap that must first be closed is to develop a more accurate picture of the true state of occupational health and safety. The MOL should develop its own database of all injuries and “near misses” and stop relying on skewed WSIB data to inform its enforcement priorities.

Inspectors have the current power to request any data they wish when entering a workplace. For instance inspectors could also ask to see all incident reports and at the same time ask for all claims filed with the WSIB. What they might uncover is numerous incidents that resulted in lost time or health care that never had a WSIB form completed but where the worker ended up on sick time benefits instead. You may also find that the JHSC/HSR or Union was never advised of these incidents where a worker actually was unable to perform usual duties or required medical attention and an opportunity for the JHSC/HSR to make written recommendations to the employer to remove the hazard was lost.

The MOL could write orders/prosecute and also share the intel with the WSIB to also consider charges or penalties.

The inspectors could also ask the employer to provide them with stats on the number of security interventions. For instance if the MOL really wants to see the how violent a workplace is they should also request from the employer security reports like the number of mental health act assists with police, number of calls to assist with a code white, aggression, med assists, threats, weapons, theft, etc.

In one workplace in just nine months, this amounted to over 2000 calls to assist. Yet WSIB 2013 violence data for health care in the entire province only shows 639 lost-

time injuries from workplace violence. In one workplace alone in 2013 we uncovered 88 lost-time injuries related just to violence. ONA has over 500 Bargaining Units and that number of 88 lost time injuries from violence is just from one of them.

For years we have told the Ministry and the WSIB about these shortcomings in the provincial data but to date there has been no will by the Ministry or the WSIB to do anything to uncover the real state of OH&S in the province. We are hopeful that our new Minister will want to uncover this information even if it means revealing that the lost-time injuries are actually much worse than he has been advised.

The MOL and WSIB should also work together to revise the existing WSIB database to accurately reflect all workplace injuries, and illnesses 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. This has been a longstanding problem and one the WSIB continues to allow and ignore despite it being made public through the Morneau Sobeco report (Morneau Sobeco is an independent consulting firm that completed a Value For Money Audit (VFMA) of the WSIB Experience Rating program in October 2008).

Furthermore, employers in Ontario should have one business number assigned to them for all government purposes so information can be cross checked. Once accurate data is gathered in this province, the MOL enforcement branch can better focus on the extent of the hazards and increase enforcement required to ensure that all poor performers are correctly identified and penalized and are no longer permitted to hide the extent of their injuries and illnesses in Ontario.

Until deterrence is set, all the prevention programs developed aimed at compliance assistance will do little to motivate the poor performers.

- b. Also, revise Section 53 of the *OHSA* and related regulations to include requirements for reporting similar "near misses" in all 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" on a construction project?
- c. The MOL should use the revised database of injuries, illnesses and other indicators, including inspections, to identify employers that could benefit from more extensive occupational health and safety audits, and order same.
- d. Another gap in the health and safety system is the lack of training for worker members of JHSCs to equip them to adequately fulfill their function.

4. Where do you see the greatest need for compliance assistance and increased awareness and why?

- a. The greatest need for compliance assistance and increased awareness in the health care sector is in the area of enforcement on contraventions instead of reliance on a defunct IRS. Where contraventions are found, inspectors should be referring employers to the Health and Safety Associations (HSAs) to work with the JHSC/HSR to meet compliance.
- b. The Health Care Regulation requires "consultation" with the JHSC/HSR on measures and procedures and training. However, many employers incorrectly consider communication to be consultation. In other words, employers will tell the JHSC what they intend to do and not receive any input from the worker members but consider that consultation.
- c. Enforcement will foster prevention. If employers and CEOs and their leadership are vigorously ordered to comply with the *OHSA* and are prosecuted when they don't comply, the prevention of illness and injury will result.

5. What do you think is the biggest barrier to workplace participation in programs aimed at achieving compliance and awareness of health and safety requirements?

- a. The biggest barrier to workplace participation is that the *OHSA* is not appropriately enforced. It is our experience that the inspectorate places too much reliance on defunct IRS's. No one at the MOL is holding individuals responsible for OH&S in a workplace (e.g. CEOs, directors, managers and Boards are not being held personally accountable for worker safety when there is the legislative authority to do so under Sections 25, 27 and 32).
- b. In the health care sector we understand that the Ministry of Health and Long-Term Care will fund legal fees incurred when an employer is charged under the *OHSA*. This is a huge barrier for having a hospital employer achieve compliance when there really is no accountability or specific deterrence set when they are subsidized by one Ministry to challenge another. This is shameful in our view.

6. What do you think would encourage or motivate workplaces to participate in compliance assistance and awareness prevention programs?

- a. Workplaces should not need to be motivated or encouraged to comply with the law. They should be required to comply. Setting deterrence through significant penalties for not complying and writing specific orders personally to senior leadership accountable for worker health and safety would encourage employers to make safety a priority.
- b. Financial incentives should only be used where employers can demonstrate, with the concurrence of the worker members of the JHSC and the unions, that they have exceeded the minimum standards of the law.

7. Are you familiar with, or do you participate in, existing WSIB prevention programs?

- a. Familiar with but not permitted to participate.

8. What are the components of these programs that you like? What are the components that you do not like? For example, components such as eligibility, the criteria for receiving incentives or the audit process.

- a. Real demonstrated change that can be confirmed by JHSC and union and where JHSC and labour are involved in the change and new measures and procedures would be the only criteria for receiving incentives.

9. What types of programs do you think would support workplaces to go beyond minimum standards with health and safety legislation and regulation?

- a. Programs that offer subsidies to employers who can demonstrate that their initiative is one that all stakeholders (workers, JHSCs, and unions) support and that go beyond producing paper but put in control measures to eliminate hazards or where that is not possible significantly reduce the risk or impact of the hazard.

For instance years ago, the MOHLTC funded health care facilities to purchase ceiling lifts and needle safety devices – this was a great initiative but could have been better if more accountability to ensure proper training was implemented on all new devices and selection of devices included consultation with the JHSC/HSR and unions.

- b. We think programs that go beyond simply having a tick box indicating the worker members and unions are involved. A true collaborative program with worker/union involvement can effect positive change, increased employee morale and decreased employer costs.

10. **Are there any sectors, workplaces or types of work that voluntary prevention programs should focus on?**
 - a. Health care has Ontario's highest injury rate for musculoskeletal disorders, workplace violence and exposures. Health care also has the second highest rate of fall injuries.
 - b. Voluntary prevention programs should only be offered through joint request from management, JHSC/HSR and unions.
11. **Do you think that financial incentives need to be a part of voluntary prevention programs that move workplaces beyond minimum standards with health and safety legislation?**
 - a. It is sad to say but without it, at least in health care, most employers just won't participate. However, if you have a system that rewards employers you must maintain and quite frankly increase penalties to employers who keep risking worker safety.
12. **What types of motivators do you think would promote participation in a voluntary prevention program?**
 - a. Public recognition to the CEO and health care facility.
 - b. Awards.
 - c. Incentives for excellence and knowledge transfer.
 - d. Significant penalties for non-compliance will motivate employers to improve their experience rating – this is our experience in several hospitals.
13. **What would motivate small businesses or workplaces that employ vulnerable workers to participate in voluntary prevention programs?**
 - a. Small business could use a mentoring plan that would involve government supports. A higher level of support from the HSA's through government funding could assist small business in developing the programs that can be used to assist other small businesses.
 - b. Financial incentive or grants to assist in exceeding minimum standards and mentoring other small businesses.
 - c. Penalize if a poor performer or misrepresenting health and safety efforts.
14. **What types of outcomes could be used to evaluate prevention programs? How would these be measured or evaluated?**
 - a. Evaluation of occupational health and safety conditions, particularly in the intricate 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 ILO corroborated the complexity of occupational health and safety evaluation when it outlined the elements for performance monitoring and measurement.¹ The ILO 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.***"

¹ Roughton, James E., Mercurio, James J., *Developing an Effective Safety Culture, A Leadership Approach*, Butterworth-Heinemann 2002, pp. xxxiv-xxxv1]

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 programs.*

15. What do you think a prevention program at the level of excellence should offer? What characteristics would a workplace need to have to reach the level of excellence?

- a. More than written procedures but a program that can be evaluated as mentioned in question #14 and puts in place true control measures that workers can confirm make a difference. There must be proof of a 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."²

16. What types of motivators do you think would help workplaces advance to the level of excellence?

- a. Including safety into CEOs accountability agreements at least in the health care sector.
- b. Penalties.
- c. Publicizing charges.
- d. Subsidies.
- e. Awards/recognition.
- f. Development of "tool kits" that supports the system and makes programs effective.

² Roughton, James E., Mercurio, James J., *Developing an Effective Safety Culture, A Leadership Approach*, Butterworth-Heinemann 2002, pp. xxxiv-xxxv1]