Ontario Nurses' Association Submission

MINISTRY OF LABOUR STRATEGY "Safe at Work Ontario (SAWO)"

2017/2018

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Introduction

The Ontario Nurses' Association (ONA) is the union representing 62,000 front-line registered nurses and allied health professionals and 16,000 nursing student affiliates across Ontario, providing care in hospitals, long-term care facilities, public health, the community, clinics and industry.

We want to thank you for inviting us to participate on January 18, 2017 in what was one of the best run SAWO consultation sessions to date. We felt the session was very adaptable to our needs and truly appreciate the Ministry of Labour (MOL) adding the question about what the MOL and system can do better to protect workers. We would like to propose that this question be added to all future consultations as it gives stakeholders an opportunity to collectively share ideas that could create better opportunities for consistent and stronger enforcement. It could also better inform the MOL on opportunities for possible system changes that could create better efficiencies within the MOL.

The feedback we are providing in this submission will either further expand on areas raised during the consultation meeting, provide new suggestions for your enforcement strategy or highlight significant problems that are putting our members at risk.

We want to also acknowledge the work the Labour Minister and Minister of Health and Long-Term Care have undertaken provincially to protect nurses and other health-care workers from infectious disease outbreaks (i.e. A Plan to Building a Ready and Resilient Health System, which aims to manage future or escalating infectious disease threats) and, through the Executive and leadership table, to jointly address the prevention of workplace violence.

Unfortunately the work to date of the Leadership Table has not yet made a difference to our front-line members with respect to workplace violence. They continue to report to us concerns about the increase of violence in their workplaces province wide and the lack of employer and supervisor commitment and response to address their concerns and protect them with the appropriate measures, procedures, staffing, equipment and training they need to safely perform their work and care for their patients. We are extremely disappointment at the lack of meaningful orders and enforcement in protecting our health and safety.

Post-Traumatic Stress Disorder (PTSD)

Our members also cannot believe and continue to voice anger over being excluded from the *Supporting Ontario's First Responders Act 2016* (re: Post-Traumatic Stress Disorder). We urge the Labour Minister, with support from the Health Minister and Premier of Ontario, to openly acknowledge that nurses should also be considered first responders and include them in this important legislation. The Health Minister heard first-hand at our Biennial Conference in November 2016 how angered and upset over 900 ONA nurse attendees were over their exclusion from this Act, and from the lack of protection from the government in keeping them safe from workplace violence. We are encouraged that the Health Minister has agreed to liaise with the MOL on this important issue for nurses in Ontario.

Fourteen years post-SARS and more than 11 years after the murder of our member Lori Dupont, our members still believe their employers are doing little to protect them.

Nurses need the MOL, the MOHLTC and Premier of Ontario to step in and make health-care employers comply with the *OHSA* and its regulations. And where the Act and regulations are not clear enough or don't allow the MOL to adequately hold employers and their CEOs, Boards of Directors, Vice-Presidents, Directors and managers/supervisor accountable for the prevention of workplace violence, we ask the Labour Minister to urgently make the necessary amendments.

What is required for a safe workplace?

The *OHSA* and its regulations and any new amendments to the Act or regulations must ensure that inspectors will be able to, through enforcement, hold these senior health-care leaders accountable to demonstrate commitment to preventing workplace through actions, and to plan for, establish and consistently implement proper control measures, procedures, equipment, training system-wide. This must include:

- **Safe staffing and security guard levels**. For example, orders should be written when there is evidence that a shortage in staffing from any skill mix (nursing, security etc.) puts workers at increased risk of workplace violence and the employer did not take every precaution reasonable in the circumstances to protect workers. Inspectors would need to determine if the manager/employer made every attempt to call in additional help/security/nurses and/or implement their surge or safe-staffing procedure to deal with such situations, etc. If such procedures do not exist, the inspectors should order the employer to develop them and ensure they can realistically protect workers.
- **Security guards who are properly trained** and are required to intervene and detain a patient when a worker or another patient is being assaulted.
- **Electronic and visual system (flagging system)** that also tracks a person's history of violent behaviour, triggers, behaviours and safety measures for the patient and workers, and requires specialized care planning to minimize triggering the patient and protects all workers at risk. The information should be available for future submissions.
- **Proper personal panic alarms** linked to security that actually have the ability to summon immediate assistance when an assault is in progress. Having a Code White procedure or panic buttons on walls or even wearing a screecher that only makes noise must not be considered a means for summoning assistance **when violence is occurring**. These measures might work when violence is likely to occur or can be anticipated but does nothing to assist a worker who is working alone in a patient's room and the patient starts attacking and beating the worker. These assaulted workers report they are not able to reach the wall or run to the nursing station to call a Code White. Screecher alarms should only be used with other controls until employers are able to implement proper personal panic alarms, as they actually do not have the ability to summon immediate assistance and are dependent on someone actually hearing them and responding.
- **Adequate risk assessments** that assess the entire workplace, including environmental/security needs, patient acuity, population, work flow, communication, staffing and security shortages, and other gaps in policy, measures and procedure, and other deficiencies, etc.
- **Training:** A minimum of two days yearly in **classroom training**, with refreshers on de-escalation, break-free, safe take down, self-defense, use of force and weapons training for all workers working in the highest-risk areas and high-risk hospitals.
- A minimum of ½-day training on de-escalation and break-free for all low-risk workers (e.g. administration staff not exposed to patient care areas).
- A minimum of two days initial training as above, and then one day in-classroom training yearly thereafter, with refreshers for all other workers at risk on de-escalation, break-free, safe take down and self-defense.
- Appointing and maintaining **supervisor competency**.
- Conducting **root-cause investigations**.

The MOL recently revised and strengthened the Workplace Violence Prevention section in its 2016/17 sector plan as a result of a recommendation from the Leadership Table. There is now a greater emphasis in the plan on compliance expectations, and we hope that emphasis will continue in all future iterations of the sector plan. However, we have yet to see those changes reflected in action by MOL inspectors at the front-line in holding employers, CEOs, Boards and their management accountable to protecting workers through **individual orders and charges where the evidence supports such charges**.

Policies and Procedures
To ensure consistency and strong enforcement, the MOL must also close its own gaps, and once and for all, revise and strengthen its Policy and Procedures (PnP) manual on workplace violence. This would include removing any direction that currently limits an inspector's ability to fully enforce the *OHSA* and its regulations. To demonstrate commitment in preventing workplace violence, the MOL must also provide adequate training to its inspectors on the changes in the PnP manual, and provide further training to inspectors on laying charges for violations of the *OHSA* and its applicable regulations. The MOL should also ensure that inspectors receive training in health-care risk assessments, so gaps such as those mentioned throughout this submission are easier to identify.

Orders
Changes to the PnP manual and inspector on-board training and blitz/enforcement initiatives training must include giving direction to inspectors to look for evidence and write orders for:

- A lack of control measures, procedures, training and management accountability/supervisor competency in areas as those listed above and throughout this submission under Sections 25 and 27, in particular with a focus on: Section 25 (2) (h); 27 (2) (c); Section 32 Duties of Officers and Director; Section 62 (5) (Obstruction); Section 32.0.1 to 32.0.5 Violence Provisions; and Sections 8, 9 and 10 of the health care regulation.

When is enough, enough?
At some point Employers and CEOs must be held accountable for their actions, or lack thereof. When is enough, enough before a CEO or Employer is going to be charged?

Staffing
Prior to violence legislation being implemented, the PnP manual included reference to staffing, but for some reason this was removed when violence legislation was enacted. Reference to staffing shortages in the context of how it may put workers at increased risk of injury or illness must be reinserted.

In last year's SAWO submission we wrote: "The Minister himself in October 2015 told his Section 21 Committee that if staffing shortages are creating a risk to worker safety he would want to know about this. Yet our health and safety specialist has personally been told by MOL senior leadership that inspectors are not allowed to write orders for additional staff, even where the evidence in a violent assault indicates a staffing shortage contributed to an assault that injured a nurse or other health care worker." Even as recently as last week, an inspector at one of our western Ontario hospitals told our Bargaining Unit President that inspectors do not get involved in staffing issues and that this issue needs to be brought up at other committees.

The staffing issue from the perspective of occupational health and safety must be addressed once and for all. It was a contentious issue that we really were not allowed to properly address even at the Leadership Table as it was met with extreme resistance from the Ontario Hospital Association (OHA). We ask the Minister to do what is right and change your policies, practices, training and the law (if it in any way prevents you from allowing such enforcement), and allow your inspectors to enforce the law fully and let the evidence dictate what orders are written. Currently, it appears the OHA's voice is being heard over the voices of front-line health-care workers who are risking their lives every day to care for their patients, and in the process are getting beaten up on a regular basis. This must end!

On-Boarding and Blitzes
Changes to the PnP manual, on-board training and blitz/enforcement initiatives training must also include giving direction to inspectors to look for evidence and write orders under the specific violence provisions in Section 32.0.1 – 32.0.5, including when:

- Employers have not conducted adequate risk assessments.
- Employers have not implemented measures and procedures to control the risks identified in any risk assessment(s) they have conducted.
- An employer cannot demonstrate that it has a facility-wide system in place to track persons with a history of violent behaviour, as noted above. It must give direction that inspectors should look for procedures and evidence that employers are not removing the flag, unless they did so because of a successful appeal finding that the person does not in fact have a history of violent behaviour.
- Employers fail to reassess the risk caused from staffing shortages and fail to put in place appropriate control measures and procedures to control the risks caused by those staffing shortages.

SAWO strategy usually includes blitzes or initiatives. Therefore, to support the Workplace Violence Prevention in Health Care Leadership Table, the health-care sector plan and what we hope will be a newly revised MOL PnP manual, with a heightened enforcement focus on workplace violence, we recommend the MOL engage in a very specific and targeted initiative in all hospitals that focuses on the controls and potential violations as highlighted below. We also suggest you expand enforcement initiatives to long-term care homes and with community employers as well.

Further, we recommend that the initiative not just focus on if the employer has a written policy, measure or procedure, or has done some training, but check to see if it is implemented system-wide consistently and is actually protecting all workers at risk. We also highly recommend that you build into field visits requirements to speak to front-line workers and supervisors. Doing so will allow you to check compliance and to test if the training they received was adequate to provide them the skills and competencies they need to safely understand the procedures and perform their work.

We also recommend that at every field visit you also require inspectors to check compliance by speaking with ONA's JHSC worker representatives and ONA's Bargaining Unit President (e.g., ask them if they get accident/illness notifications with all the prescribed information within four days). We highly recommend that any field visit or initiative include spot checks/audits of specific high-risk and other inpatient units.

A simple example

In a recent site visit to a large hospital, ONA's health and safety specialist and I were able to audit and identify gaps in personal alarm distribution and usage and a faulty flagging procedure and system in less than 10 minutes by simply speaking to workers and checking compliance with front-line managers. In this case, the manager said all staff members have personal screecher alarms as an interim measure until the new personal alarm system is implemented in her unit. We asked her where her alarm was and she apologetically said, as she fumbled to find it, that it was in her pocket. When she put it on, I quickly noticed it had only one break away point, which in itself could be a choking hazard. We indicated that she can't expect staff to comply if she does not lead by example and enforce the policies.

The next worker we approached did not even know what a screecher or personal alarm was, but when it was explained to her, she thought it was a great idea. Another worker did not have her alarm on her (she left it in the staff room during a meeting), and another also had it in his pocket because when he was charting, it dangled and caused difficulties. This observation took all of four minutes to determine employer and supervisor non-compliance.

The senior leader we were touring with looked at me and said, "I get it," and we do believe this employer will now make the necessary changes at the top to: monitor director and manager

compliance; ensure consistent distribution of alarms; replace hazardous lanyards worn by the workers; and consistently enforce their practices and policy.

In the next five minutes of the tour, I observed that the white board was used to identify patients with a history of violent behaviour, and while it was a good start, that in itself would not comply with the law as it only indicated a V for violent and did not provide the information needed to protect workers from physical injury. Information that could protect workers would include triggers, behaviours and safety measures for the patient and worker. None of this was required in the actual flagging procedure and therefore gaps risking worker safety continue to exist.

Again, we are confident that this brief five-minute observation will result in changes to the employers flagging procedure and practices.

Inspectors should also do spot checks/audits and test compliance, as doing so will assist employers in identifying gaps in their system-wide program. This will also create efficiencies within the MOL by decreasing the number of return visits in the future. Employers will soon comply as they come to realize that it is not okay to fix a problem in one unit while the same problem or deficiency exists in many other units, including deficiencies or gaps with their program's written measures, procedures and training.

Inspectors - Orders

The PnP manual and all training should also be amended to give direction that inspectors at each visit, in addition to addressing specific complaints, will also look for evidence and issue orders when:

- Employers are not complying with the health-care regulation and consulting Joint Health and Safety Committees (JHSCs) in the development of written measures, procedures and training that may impact worker safety, including those that are often considered to be clinical in nature but still impact worker safety (e.g. restraints procedures).
    - Many employers develop a new procedure or training and then just report on it at a JHSC meeting, and then use that to say that they have consulted when the new procedure or training was already approved and/or finalized.
- Employers are not providing adequate training on all measures and procedures that impact worker safety, which is required under the health care regulation.
- Employers are not providing adequate training in de-escalation, break-free, self-defense, safe take down, use of force and weapons, etc., based on the risk to workers (for instance, Crisis Prevention Institute [CPI] training does not teach safe take-down skills – we have actually called CPI and they confirmed this); often employers only provide one day of the two-day program even to workers who care for high-risk patients. The MOL must develop a plan to address this gap so inspectors no longer accept that employers just retrain or train workers on a program that will not adequately protect them.
- When employers do not adequately respond to written recommendations of the JHSC or a single co-chair.
- Employers are not consistently providing accident notification and all prescribed information to JHSCs and the Union within four days of any accident or illness.
- Employers are not reporting all critical injuries to the JHSC, the Union and the MOL.
- Employers are not providing proper steps to prevent a recurrence in their accident notification determined through a root cause investigation.
- An employer is obstructing the work of a JHSC member (like not allowing all JHSC members time off to attend JHSC meetings or conduct inspections).
- There is evidence of supervisor incompetency (a supervisor's inaction to resolve a safety concern would be evidence of supervisor incompetency).

- There is evidence that employers failed to provide reports to the JHSC pertaining to occupational health and safety, such as incident reports, investigative reports, risk assessments, testing results, etc.
- There is evidence the employer has a written measure or procedure and has not trained its workers on it (email notification of a new policy must not be accepted as training).

Inspectors should also be required to leave any orders and detailed narrative on the day of the field visit and not have to return the following day, as seems to be the case in health care and with respect to workplace violence, in particular, over the last few years. This practice leads us to be suspicious of the process and concerned that there is management interference in allowing inspectors to fully do their jobs. Any such interference in our opinion should be viewed as obstruction of an inspector under Section 62 (1) of the *OHSA.* The MOL must appropriately change its systems and train inspectors adequately to allow them to fully do their jobs and enforce the *OHSA* and its regulations.

Chief Prevention Officer

The Chief Prevention Officer (CPO) rarely consults with our union and the Minister's Section 21 Committee. The CPO is responsible for the grants that are awarded for innovation and research to improve worker safety. The CPO also sits on the Workplace Violence Prevention in Health Care Leadership Table, which by now should have provided great insight into the risks that our members face every day from workplace violence. The CPO did support the Public Services Health and Safety Association (PSHSA) Violence Aggression and Responsive Behaviour (VARB) project. However since then we have not seen any further dedicated funding to develop additional tools that are usable across the health care sector system such as those suggested by the Leadership Table.

We were very encouraged when the announcement for the 2016/2017 Research Opportunities Program (ROP) included workplace violence, however on further review it was identified that the research call placed limitations that prevented acceptance of any proposal that wished to evaluate existing tools like those that were developed through the VARB project. It is also still unknown if any submissions for the prevention of workplace violence in health care will be accepted.

The latest announcement on January 23, 2017 for Occupational, Health, Safety and Prevention Innovation Program (OHSPIP) funding was not directly linked to the prevention of workplace violence. It is also hoped that strategies for protecting our nurses and other emergency responders from emerging issues like exposure to fentanyl and carfentanil will be accepted under the Occupational Disease heading for this funding.

The CPO news bulletins, such as those released for male-dominated industries like mining and construction, rarely mention anything related to health care.

CPO Powers

Recently, through Bill 70, the government introduced law giving the CPO powers that allow him to implement an accreditation program and set the standards for accreditation. All of this was done without any prior consultation with ONA or other labour unions, all of whom are extremely concerned about what impact such a government accreditation program would have on enforcement.

The CPO reports directly to the MOL, and therefore we ask the Labour Minister to allow/require the CPO to:

- Focus and dedicate significant resources to health-care worker safety, including workplace violence prevention.
- Consult with ONA on any initiatives or changes to law beforehand that could impact our

members' health and safety.
- Create a health-care section for his news bulletins/reports, etc., that will focus on and speak to health-care employer obligations to protect workers under the *OHSA*/applicable regulations, and which will alert stakeholders to any new projects/updates/initiatives that may impact health-care worker safety, including promoting the VARB tools and the work of the Leadership Table.

SAWO Blitzes/Initiatives – One Year Inititiative
As expressed at the SAWO consultation, we prefer the idea of a one-year initiative as opposed to short-term blitzes, which are not as impactful as there is little opportunity for inspectors to follow up.

Furthermore, any SAWO initiative must be flexible to allow inspectors to address any new concerns they uncover during their investigative trail or that are brought to their attention by workers during their visits. During these field visits, inspectors often hear about unresolved hazards and supervisor or employer non-compliance, but because those issues were not part of the blitz or initiative's focus, they are not being allowed to address them or areas of non-compliance. It is our recommendation that MOL allow and build into enforcement initiatives time for MOL inspectors to use their intelligence, training and expertise to follow leads, and enforce and follow tips.

System Wide Gaps
Any MOL enforcement initiative must also focus on identifying gaps system-wide, account for how and why issues are occurring, and ensure that inspectors are being required to ask questions about processes in place, not just in one unit but all units. During these visits, as stated earlier, inspectors should be required to do spot checks/audits with workers on the front-line to see if the employer practices are actually in place 24/7.

One employer representative told our specialist last year that they were busy preparing for possible MOL inspections and ensuring that all managers and workers were told where their workplace safety binder was, so if asked by an inspector, they would indicate knowledge of the processes. In checking with our Bargaining Unit reps however, workers were not actually trained on these procedures as required under the Act and health-care regulation. This unfortunately is our reality. Adequate time needs to be built into these MOL initiatives for inspectors to dig deeper and uncover the gaps.

Investigations – Resolving Hazards
When looking at the Internal Responsibility System (IRS), inspectors should not only check to see if there is a system for workers to report incidents, but also check to see if the employer and managers are actually investigating all incidents (including near-misses) and resolving the hazard, or where it can't be eliminated, minimizing the risk to workers to the greatest extent possible.

We suggest you ask for copies of professional responsibility complaint forms as they often contain evidence that managers have been made aware of hazards. Workers often include safety concerns in these forms assuming managers will address all concerns. Unfortunately, many managers only read the professional responsibility issues and completely disregard the worker safety concerns. Inspectors should be required to ask health-care managers how they protected workers and resolved those health and safety issues identified in professional responsibility complaint forms.

Inspectors should also question managers about how they investigate incidents and if they conduct risk reassessments when they learn of staffing shortages for instance or an increase in

patient acuity and population. If they can't demonstrate knowledge of the *OHSA* or of the hazards in the workplace and can't demonstrate action taken to protect workers from those hazards, inspectors should then be required to issue orders for the employer to train all managers to make them competent and responsive to hazards and worker concerns about safety. Inspectors should also review inspection and risk assessment reports, and then ask for proof of action to control all the risks identified. If the risks have not been controlled, inspectors should be supported to issue orders, and if a control will take time to implement, inspectors should also be supported to issue orders for interim measures until the risk is properly controlled.

Deliverables
Any SAWO initiative must also ensure and monitor the deliverables. One such deliverable should include orders requiring employers to provide, as noted above, accident/illness notification information within four days to the JHSC, to the Unions and to the MOL as applicable containing all of the prescribed information. Proof of compliance must also occur as part of any enforcement strategy, which means inspectors should be required to go back and check dates and information provided on notifications sent to the JHSC and confirm receipt of all required information. Inspectors should also return and speak with JHSC worker members and Bargaining Unit union leaders to see if they are also in fact getting these notifications. If not, and the employer indicated they had complied, these employers should be held accountable.

Compliance
Compliance with the accident/illness notification section of the Act is mentioned in the 2016/17 sector plan and has been referenced in many other sector plans in the past. However in practice, inspectors are still not writing these orders, leading us to believe there is MOL internal direction on this issue preventing orders from being written. Perhaps enhanced training on this issue is necessary. MOL senior leadership needs to monitor the deliverable to ensure it is met. This must be a priority for the 2017/2018 enforcement strategy.

Musculoskeletal Disorder, Infectious Disease, Psychological Safety
We have spent a lot of time focussing on workplace violence in this submission but we also want to make it clear that all of the principles for good effective inspections and enforcement should also be applied for musculoskeletal disorder (MSD) hazards (which are still the highest injury causing hazard in the health-care sector) and for infectious diseases, and slips, trips and falls. We also would like to see MOL begin to focus on psychological safety in our workplaces.

Hallway Nursing
Another hazard which we raised at the last consultation and many others is hallway nursing. Employers do not think hallway nursing is a hazard that places our nurses' safety at increased risk. One representative from the Health Care Section 21 Committee was even bold enough at the last meeting held in January to justify hallway nursing by saying something like, "as long as there is three feet available in the hallway, it's ok." I would ask you to look at the attached CTV video footage capturing a patient trying to disarm a police officer in a hallway at Humber River Hospital while numerous stretchers, some with patients in them, were lined up in harm's way of this patient during this incident. http://www.ctvnews.ca/canada/security-footage-shows-man-attempting-to-steal-officer-s-gun-1.3241288?hootPostID=e3d51a36cf9e3cb1b29775908d16f4d5

Any nurse working in that unit would also have been at risk that day and other days from workplace violence, not to mention the slip, trip and fall hazards, MSD injury risk and risks of infectious disease, due to care being provided in an uncontrolled environment. We ask that MOL once and for all address hallway nursing during its SAWO blitzes/initiatives and during all field visits.

2016/17 Sector Plan
The 2016/2017 sector plan lists a number of other hazards that also require enforcement and we have reviewed that list and all of the hazards are still a concern for our members.

Enforcement
MOL enforcement to date is not making the type of difference that it should in the health-care industry. While the sector plan in theory looks impressive and even states that inspectors will look to see whether directors and officers of a corporation are complying with the requirements of the *OHSA* Section 32, in practice inspectors are still not issuing orders or charging directors and officers under this section for not complying with their obligations, despite our repeated pleas to do so.

ONA believes the lack of MOL demonstrated, meaningful and consistent enforcement along with what appears to be MOL director and senior leadership resistance to hold health-care employers, CEOs, directors and management personally accountable for not complying with the *OHSA* and its regulations, is still putting our members' health and safety at risk.

The Leadership Table has given us renewed hope and we look forward to seeing how the Ministers of Labour and Health will both exercise their powers and enforcement abilities and demonstrate that they will in 2017/2018 hold individual leaders in health care accountable for complying with the *OHSA* and applicable regulations, and do everything in their power to protect the safety of our nurses and other health-care workers.

In next year's SAWO submission, I want to report that, thanks to the good work of the Leadership Table and support from both Ministers, our front-line nurses are seeing a change in the orders the MOL is writing and with their employer and supervisors in protecting them from workplace violence and other hazards in the workplace.

The SAWO consultation notes taken during the session by the MOL contain many more ideas that we won't reiterate.

We do hope you will take all of our feedback in this submission, feedback provided at the January 18, 2017 consultation, and implement all of the recommendations from the Leadership Table, including those where we could not reach consensus (but had majority consensus), and use it to amend/strengthen our safety laws to develop one of the best and most effective and powerful enforcement strategies/initiatives to date. We need more than "best practices" to save our nurses from their unsafe work environments.