

Ontario Nurses' Association Submission

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

2018/2019

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ONTARIO NURSES' ASSOCIATION

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Introduction

The Ontario Nurses' Association (ONA) is the union representing 65,000 registered nurses (RNs) and health-care professionals and more than 16,000 nursing student affiliates providing care across Ontario in hospitals, long-term care facilities, public health, the community, clinics and industry.

Post-Traumatic Stress Disorder (PTSD)

On behalf of all of our members, we are very pleased for Minister Hoskins' announcement at our December 2017 Biennial Convention that the *Supporting Ontario's First Responders Act 2016* (re: Post-Traumatic Stress Disorder) will be amended to include nurses. We urge you to ensure this amendment is passed expeditiously.

Safe at Work Ontario Consultation Session - January 23, 2018

We thank you for inviting us to participate in the Ministry of Labour's (MOL) Safe at Work Ontario (SAWO) consultation session on January 23, 2018. This year's format for allowing participants to respond to all MOL questions on individual flip charts and then collectively reviewing and documenting those responses along with facilitating further feedback gave participants confidence that their concerns/ideas/recommendations were heard and tracked.

Management representatives attended the labour consultation session

We are concerned that our labour consultation session included several representatives from management and, as a result, not all responses are reflective of labour's position. We would ask that this registration/attendance issue needs to be corrected for next year's session. For example, one of the questions asked:

Q3: If the ministry were to develop information in the form of guidelines or codes of practice for your sector, which topics should the ministry address?

In the past, labour representatives have made it very clear in various forums and at the Workplace Violence Prevention in Health-care Leadership Table (during Year 1 in 2016) that they are not interested in codes and guidelines. Therefore, we were very surprised to see that this question has resurfaced despite our objections.

As you are aware, codes and guidelines are not enforceable. What our members need are stronger legislation/regulations and more meaningful enforcement to ensure employers are held accountable to adequately protect workers. An employer representative attending our labour session wrote "code & guidelines help small employers navigate the health and safety sector – long-term care home sector." This comment is an example of how allowing employer representatives into our session can taint labour's very strong and collective position that we do not want to see more codes and guidelines.

The strong message from the labour consultation session is it is time to focus on full enforcement of the occupational health and safety laws that already exist and to strengthen the laws and regulations that are weak and risk worker safety.

SAWO consultation questions do not encourage feedback on laws/regulations

We are concerned that the MOL's questions for these sessions are designed to discourage feedback on changes to laws/regulations and any emphasis on more frequent and effective enforcement. The limitations set out by the MOL in the questions are based on the premise that these are long-term solutions and the MOL is looking for the low-hanging fruit instead.

These sessions will only make a difference when law- and policy-makers and those leading change at the MOL hear, respond to and investigate the hazards of our health-care workers and hold employers accountable through orders. This should include charges to both the employer

and to the individual CEOs, administrators and supervisors who continue to disregard the OHSA and are not taking every precaution reasonable in the circumstances for the protection of a worker.

MOL Sector Plan 2017/18 reveals troubling enforcement data

Health-care workers (HCWs) have some of the highest rates of injuries and illness when compared to all industries. In 2016, HCWs had the highest rates of workplace violence, musculoskeletal disorders, falls, and infectious disease when compared to the mines, construction and manufacturing (see attached infographic) sectors.

The 2017/18 sector plan shows that the overall health-care lost-time injury rate only decreased by 115. This was likely due to the more stringent Workplace Safety and Insurance Board (WSIB) policy causing high rates of denials versus any meaningful prevention. One large health-care employer recently reported to ONA that only 75 per cent of their submitted claims are even allowed at the WSIB. This supports our position that any decrease is more likely due to WSIB denials, not prevention. With this kind of data it's clear to see that the majority of health-care employers are still not making substantive changes to better protect our members.

Given the ongoing high rate of injuries and illnesses to health-care workers, we would have expected to see the MOL's enforcement activities increase significantly, not decrease. Yet you will see from Table 1 below, MOL activities have plummeted to alarmingly low rates in fiscal year 2016/17 (*What's interesting is that this was the very year that the Ministries of Labour and Health joined forces to better protect nurses in hospitals from workplace violence*).

Table 2 below shows that in 2016/17 fiscal year when compared to 2015/16 data there were:

- 101 additional complaints from HCWs (735 compared to 634).
- 43 additional critical injuries.

Table 1 below however paints an alarming picture. Despite an increase in complaints and critical injuries as stated above there were:

- 985 fewer proactive inspections.
- 1004 fewer proactive field visits.
- 1500 fewer reactive field visit activities-investigations.
- 2504 fewer field visit activities.
- 757 fewer orders.

These statistics confirm what we have believed for some time: The MOL is not adequately enforcing the OHSA and its regulations with health-care employers. Our members are questioning whether their employers are somehow immune from the same stringent enforcement other industries receive simply by virtue of being a public entity or because we are working in a female-dominated sector.

Table 1. Health-care sector field visit activities and orders issued

| Program inspector activities | 2012-2013 | 2013-2014 | 2014-2015 | 2015-2016 | 2016-2017 |
|---|------------------|------------------|------------------|------------------|------------------|
| Proactive – consultations | 52 | 29 | 78 | 47 | 28 |
| Proactive – inspections | 1,700 | 1,420 | 1,680 | 1,837 | 852 |
| Total proactive field visit activities | 1,752 | 1,449 | 1,758 | 1,884 | 880 |
| Total reactive field visit activities – investigations | 1,796 | 1,694 | 2,063 | 2,066 | 566 |
| Total field visit activities | 3,548 | 3,143 | 3,821 | 3,950 | 1,446 |
| Orders issued | 3,710 | 3,340 | 4,494 | 4,834 | 4,077 |

Table 2. Health-care sector events and injuries

| Occupational health and safety events and injuries | 2012-2013 | 2013-2014 | 2014-2015 | 2015-2016 | 2016-2017 |
|---|------------------|------------------|------------------|------------------|------------------|
| Complaints | 468 | 535 | 594 | 634 | 735 |
| Work refusals | 7 | 4 | 6 | 8 | 5 |
| Fatalities | 1 | 0 | 0 | 0 | 0 |
| Critical injuries | 93 | 98 | 124 | 85 | 128 |
| Other injuries (i.e., non-critical) | 231 | 252 | 295 | 315 | 311 |

Workplace Violence and the Leadership Table

We acknowledge the work the Minister of Labour and Minister of Health and Long-Term Care have undertaken provincially through the Workplace Violence Prevention in Healthcare Leadership (Leadership Table) to better protect nurses and health-care workers from workplace violence.

While the Leadership Table brings together many stakeholders to make recommendations to the Ministers of Labour and Health, we are concerned given its Phase 2 mandate (which focuses only on guidelines and tools) that it will limit the discussions and opportunities to make real and meaningful change for our members. The Leadership Table's mandate therefore must be expanded to include recommendations for changes to the system, laws (OHS and LTCHA), regulations (e.g. *Health Care Residential Facilities Regulation*), standards, agreements and policies etc.

Our members have made it clear that guidelines and products that are not enforceable are not going to protect them in their reality. Our members need the MOL to start writing orders for security guards, staffing, proper personal panic alarms, flagging etc. They need the MOL to adequately enforce the existing OHS and its regulations and hold employers and their CEOs, Board of Directors, Vice-Presidents, Directors and Managers/Supervisors accountable for protecting workers from workplace violence.

Where the OHS and its regulations fall short, we ask the Minister of Labour to urgently make the necessary amendments to the *Occupational Health and Safety Act/Regulations*. Where other laws and standards such as the LTCHA conflict with other legislation and create situations that can lead to violent/responsive/aggressive behaviours (e.g. allowing homes to leave residents in dirty diapers until they reach a certain saturation level), then our members need the Minister of Health to make amendments to these standards and law.

Leadership Table work still not making a difference to front-line nurses

We reported in last year's SAWO consultation submission that the work of the Leadership Table has not yet made a significant difference to our front-line members on preventing and protecting them from workplace violence. The same holds true today. They continue to report to us concerns about the increase of violence in their workplaces and still report 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 disappointed with the MOL's lack of reactive investigations, field visits and orders as noted above in health-care workplaces despite the work of the Leadership Table. Years ago, the Ministry gave us their word that they would have a heightened response to health-care workers' concerns given their limited right to refuse unsafe work. The data speaks for itself. The Ministry seems to be paying less attention to health-care workers' complaints.

Further, the MOL's latest initiative on workplace violence prevention which is about to end in March has been disappointing. During this time, we have only seen four useful field visit reports with orders and three of those were generated because of ONA's complaints to the MOL. Only one that we have seen was progressive and in line with the MOL's description of its enforcement activity for this six-month initiative.

Non-consensus recommendations *still* need to be addressed

The Ministers of Health and Labour in Year 1 of the Leadership Table asked working groups to produce resources and make recommendations that would better protect our members. The labour representative of the working groups worked hard that year and produced numerous recommendations for changes to law/regulation and standards. However, a few employer representatives on these working groups would not agree to the majority of these important recommendations and, since consensus could not be achieved even though the proposed recommendations had majority support, many of these never made it into the progress report.

Leadership Table recommendation #17 on security

The key recommendation on security originally stated that in the medium term, the MOHLTC/MOL "begin work on language for the health-care regulation to include a minimum security role/function and training requirements..." Even this most important recommendation to our members was weakened and changed in the final hour by the Ministries. Nurses made it loud and clear to us that they need language in the health-care regulation for a minimum security role/function and minimum training so the MOL could no longer prevent inspectors from writing orders for adequate security. We heard from numerous inspectors that they were not allowed to write orders for security even when workers' health and safety was at risk.

The full recommendation was changed to remove all language referencing inclusion into the Health-care Regulation. The summary of recommendations in the Leadership Table progress report was also further weakened to state that the Ministries were to create a minimum security training standard. There was no mention of the changes to the law or for a minimum security role and function.

This change meant that employers would yet again have discretion to risk worker safety and not have to hire enough well-trained security based on the risk at their workplace. The only actions to implement this watered-down recommendation have been to promote a new Public Services Health and Safety Association (PSHSA) Violence Aggression and Responsive Behaviours tool on Security. While this tool is very useful for those who voluntarily choose to use it, accessing it and being able to voluntarily implement it does not remotely address our members' concerns as noted above.

As the Leadership Table heard in Year 1 from Michael Garron Hospital, there is a huge benefit of having enough adequately-trained security guards in our hospitals. Michael Garron Hospital has been able to reduce their use of force from over 50 per cent from 10 years ago to less than 5 per cent of the time in the last few years thanks to their well-trained staff security team. Not only is this better for worker safety, but better for patient care as well. This should be a priority for both the Ministers of Labour and Health.

Action: For Phase 2 of the Leadership Table, the Ministers of Health and Labour take the lead and bring back the original recommendation on security and ensure it is included in the health-care Regulation. The language should include having a minimum security role/function and minimum training for those performing the role of security.

The minimum training must be equivalent to the classroom training recommended by the *Canadian General Standards Board Guidelines*. In addition, security guards must receive training in crisis management and effective communications, hospital-specific training such as different types of restraint application as part of an overall least restraint program, and mental health act training as the minimum standard in accordance with the organization's patient population.

Action: Once enacted, the Minister of Labour must enforce this new language.

Consultation paper questions

What is required for a safe workplace?

- **Personally hold CEOs, Boards, senior leaders and administrators accountable** – amend the OHS Act Section 32 and create a requirement that all Board of Directors, CEOs, senior leaders and administrators of Long-term Care Homes (LTCHs) take a minimum mandatory one-day health and safety due diligence and OHS training.
- **Amend OHS Act and make it explicit that all employers must appoint competent supervisors and maintain supervisor competency by providing all supervisors -- including senior leaders -- with a minimum core training similar to that required in the mines and enforce this once it is enacted.**

An example of supervisor and senior leader incompetence happened recently in one of our larger hospitals just outside of Toronto. A patient walked into the main entrance and spoke to a supervisor. He indicated he had a bomb and asked, "Where is the emergency room?" The supervisor then directed him to the emergency room. This supervisor did not warn workers of the risk immediately, nor did he call the police. When the unit supervisor learned of the situation, she also did not warn workers and told the nurse not to call a code. Thanks to our dedicated nurse worried for her patients' safety, she called the police.

The patient ran out of the emergency room and dropped the bag in the unit. While police were apprehending the patient, the supervisor again demonstrated her incompetency by beginning to open the bag which was supposedly holding a bomb. The police came in and hollered at her to stop. Then if that is not enough to demonstrate supervisor incompetency the senior VP who claims she knows health and safety well wrote to staff following the event about the great job the supervisor of the unit did in managing this situation.

The MOL was called in because the employer did not recognize what went wrong in this situation. No one would have expected that MOL inspectors would have wrote orders holding the employer accountable to ensure they have competent supervisors. This however was not the case yet again. Instead we received two orders telling the employer to revise two policies – that's it. This is not an isolated story. We have many incidents that demonstrate supervisor incompetency and many that demonstrate that the MOL may not be looking into this problem which is risking the safety of our members and health-care workers.

The employer had provided some competency training in the past, but clearly it was not effective. This and in addition to the many other horror stories we have, are great examples of why employers must be required to meet a core supervisor competency and maintain and demonstrate competency.

The OHS Act and its regulations and any new amendments to the *Act* or regulations must ensure that inspectors will be able to, through enforcement, hold senior health-care leaders accountable to demonstrate commitment to preventing workplace violence through actions and to plan for, establish and consistently implement proper control measures, procedures, equipment and training system-wide. This must include writing orders on existing laws/regulations or making amendments to law/regulations so orders can be written for:

- **Safe staffing and proper number of security guards with proper training.**

- **Electronic and visual alert system in all health-care workplaces (flagging system)** that also tracks a person's history of violent behaviour, triggers 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 readily available and easily accessed for future admissions.
- **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 alarm 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 it 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/or responding.
- **Adequate risk assessments** that assess the entire workplace including environmental/security needs, patient acuity, population, work flow, communication, staffing and security guard shortages and training for guards, and other gaps in policy, measures and procedures, and other deficiencies.
- **Training:** A minimum of two days yearly in **classroom training** with refreshers on de-escalation, break-free, safe take down, self-defense/protection, restraints training for all workers working in in-patient units where there is a risk of being exposed to patients with a history of violent behaviour and three days of in-classroom training as above for all workers working in high-risk units and hospitals, plus use of force and weapons training.
- A minimum of a half-day training on de-escalation and break-free for all low-risk workers (e.g. administration staff not exposed to patient care areas).
- 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 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 OHS Act 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 OHS Act and its applicable regulations. The MOL should also ensure that all inspectors receive training in health-care comprehensive 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.

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."

The staffing issue from the perspective of occupational health and safety and the MOL's lack of enforcement must be addressed once and for all. It was a contentious issue that we were not allowed to properly address at the Leadership Table in Year 1 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 their evidence dictate what orders are required and written.

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, their triggers, behaviours and safety measures for workers and the patient, as noted above. It must give direction that inspectors should look for evidence that employers are not removing the flag unless they did so because of a successful appeal finding that the person does not 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 staffing shortages.

SAWO strategy usually includes blitzes or initiatives. Therefore, to continue to support the Workplace Violence Prevention in Healthcare 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 continue to engage in a very specific and targeted initiatives in all hospitals, LTCHs and with community care employers that focuses on the controls and potential violations as highlighted in this submission.

Further, we recommend that the initiative not just focus on whether 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 some requirements to speak to front-line workers and supervisors. Doing so will allow you to check compliance and to test whether 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). Ask them if they have any concerns with the employer's flagging system. Ask them if the flagging system tracks a history of violence that occurred outside of the hospital etc. We highly recommend that any field visit or initiative include spot checks/audits of specific high-risk and other inpatient units to test implementation of measures and procedures the employer states they have in place.

A simple example

Last year, we reported about a site visit to a large hospital with ONA's health and safety specialist and ONA's former President. We 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. We indicated that she can't expect staff to comply if she does not lead by example and enforce the policies.

A year later, we audited a different mental health floor with this same employer but were late arriving as we took a detour to audit the emergency room while there. As we walked on the unit, two food workers pushing a cart were leaving and our specialist again asked do you have screechers and they asked, "What are they?" When she explained, the workers said "Oh, are those the things the manager just told us about and told us to wear." One year later, and there is still no consistency. Those workers had not been trained and had not received an alarm.

Having inspectors do more spot checks/audits, test compliance and write orders 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 inspector training should 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 called CPI and they confirmed this). Often employers only provide one day of the two-day CPI program to workers who are exposed to and/or 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 (for example, 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 over the last few years. We are hearing this is an internal directive from the MOL.

The MOL must appropriately change its systems and train inspectors adequately to allow them to fully do their jobs and enforce the OHS Act and its regulations.

Investigations – Resolving Hazards

When looking at the Internal Responsibility System (IRS), inspectors should check to see if there is a system for workers to report incidents. In addition inspectors should check whether the employer and managers are investigating all incidents (including near-misses) and resolving the hazard or to minimize 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 regarding 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 disregard the worker safety concerns. Inspectors should be required to ask health-care managers how they protected workers and resolved those 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, an increase in patient acuity and population). If they can't demonstrate knowledge of the OHS Act 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 be supported to issue orders for interim measures until the risk is properly controlled.

Compliance

Compliance with the accident/illness notification section of the *Act* is mentioned again in the 2017/18 sector plan and was referenced in many other sector plans in the past. However, in practice, most inspectors are not writing these orders even though we were told it is part of the

workplace violence six-month MOL Initiative. Ensuring the employer is actually complying with the OHSa and its regulations must be a priority for the 2018/2019 enforcement strategy.

Musculoskeletal Disorders, Infectious Disease, Psychological Safety

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

Hallway Nursing

For years, we have been raising hallway nursing and to our knowledge, the MOL has not addressed this issue. We would appreciate knowing how many orders the MOL has written for hallway nursing in the last year. If not, why not and is the MOL closing a blind eye to the hazard?

2017/18 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

To date, MOL enforcement is not making the type of difference that it should in the health-care industry. While the sector plan in theory looks impressive, it does not clearly state that the MOL will look to see whether directors and officers of a corporation are complying with the requirements of the *OHSa* Section 32 and will hold them accountable. We do not want it to take the death of another nurse before health-care employers are held accountable.

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.

We do hope you will take all of our feedback in this submission, feedback provided at the January 23, 2018 consultation, and implement all of the recommendations from the Leadership Table, including those where we could not reach consensus (but had majority support) 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" guidelines and products to save our nurses from their unsafe work environments.