

OPSEU/ONA

**FINAL RECOMMENDATIONS TO
JUSTICE CAMPBELL**

REGARDING:

**OCCUPATIONAL HEALTH AND SAFETY
MATTERS ARISING FROM SARS**

JULY, 2004*

* This is a revised version of the recommendations submitted to the SARS Commission in July, 2004. It has been revised and formatted for this website.

Table of Contents

1.	RECOMMENDATIONS CONCERNING PROVINCIAL OPERATIONS CENTRE DIRECTIVES:	2
2.	RECOMMENDATIONS CONCERNING MINISTRY OF LABOUR: POLICIES AND PROCEDURES: ...	5
3.	RECOMMENDATIONS CONCERNING THE OCCUPATIONAL HEALTH AND SAFETY ACT:	11
4.	RECOMMENDATIONS CONCERNING THE REGULATION FOR HEALTH CARE AND RESIDENTIAL FACILITIES AND REGULATION 834 CRITICAL INJURY DEFINED.....	20
5.	RECOMMENDATIONS CONCERNING THE WORKPLACE SAFETY AND INSURANCE ACT:	23
6.	RECOMMENDATIONS CONCERNING WORKPLACE SAFETY AND INSURANCE BOARD PROCEDURES:	23
7.	RECOMMENDATIONS CONCERNING INFECTION CONTROL MEASURES	25
8.	RECOMMENDATIONS CONCERNING EDUCATION AND NEW EMPLOYEE ORIENTATION.....	28

ONA/OPSEU

FINAL RECOMMENDATIONS TO JUSTICE CAMPBELL

REGARDING:

OCCUPATIONAL HEALTH AND SAFETY MATTERS ARISING FROM SARS

JULY, 2004

1. Recommendations Concerning Provincial Operations Centre Directives:

- a) **That in a future health care crisis requiring the activation of a Provincial Operations Centre (POC), that the structure, membership and mandate of the POC be immediately communicated to stakeholders and the public; and that in future crisis situations the work of the POC be made more transparent to stakeholders.**

Rationale: In the early days of SARS, unions and workers were unaware of the existence of the Provincial Operations Centre. Even when the unions were informed of the POC and had some understanding of its role, they did not know the makeup of the POC, have a clear idea of the authority of the POC, or know how to gain access to the POC for an explanation of its decisions or input into its decisions. This communication gap prevented both unions from being able to respond effectively and in a timely fashion to our members' concerns. Stakeholders must be defined to include all Unions representing involved health care workers.

- b) **That in the future, when the Ministry of Health and Long Term Care receives notification from any source of the potential for a serious infectious disease outbreak, that all stakeholders be immediately notified.**

Rationale: After the SARS crisis was over, the unions learned that as early as March 14, 2003 and perhaps even sooner, the MOHLTC had sent out a physician letter warning of the possible arrival of SARS in Ontario. It was almost two weeks later that this information was relayed to health care workers (HCWs). It is possible that earlier notification of HCWs may have prevented some of the spread of SARS.

- c) **That the development, including the process and rationale, to amend, revise and post Directives must be transparent and easily understood, especially by the stakeholders who must implement the Directives.**

Rationale: The documents received by the unions clearly demonstrate the lack of communication and lack of transparency especially in the early days of the crisis. There was little attempt to solicit union input into problems with the Directives and the way in which the crisis was being handled, and where union input was sought, it was not at all clear what impact if any, the

unions' contribution had. Throughout the crisis, there were problems and shortcomings in the Directives that the unions identified but could not address successfully.

- d) That in the future, all MOHLTC/POC communications related to infection control/health and safety matters, be immediately forwarded to all affected parties including Joint Health and Safety Committees and all unions representing workers in these workplaces. And that such communications be posted in a fashion accessible to all workers.**

Rationale: During the SARS crisis, Joint Health and Safety Committees were not provided with copies of the Directives. For that matter, in many facilities, JHSCs did not meet during the crisis. In many facilities, the Directives were not posted in their original form and the employer's interpretation of the Directives was distributed to various hospital units. It is the unions' position that JHSCs are entitled, under the OHS s.25(2)(l), to each of the Directives relevant to their facility and that the Directives should be posted for all workers to see (s.25(2)(m)). To clarify the process for distribution of the Directives, the Directives themselves should include a distribution list that includes the JHSCs.

- e) That all MOHLTC/POC communiqués and Directives that affect worker health and safety will reference the Occupational Health and Safety Act, its regulations and appropriate standards and guidelines. It must be clarified that the OHS Act and its regulations remain the law even in a provincial emergency.**

Rationale: As a result of union involvement, the latest Directives developed by the MOHLTC do reference the Occupational Health and Safety Act and its regulations. However, this was not the case during the SARS crisis and contributed to the difficulties the unions and workers faced when attempting to address occupational health and safety issues as the Directives were implemented.

- f) That the Ministry of Labour have a greater and more clearly defined role on a future POC when workers' health and safety is being impacted by decisions made at the POC.**

Rationale: For example, a senior Inspector and an Industrial Hygienist with expertise in infection control, should have been active participants at the POC bringing their knowledge of the legislation and workplaces to the process. This knowledge and expertise should have informed the development of the Directives and communiqués affecting workers to ensure that those documents were written in compliance with the OHS Act and its Regulations.

- g) That in future, if decisions are being made that will influence work processes, that the MOHLTC/POC consult with union representatives who have recent and extensive knowledge of those work processes. In addition, that representatives with expertise in health and safety from the affected unions be consulted and work closely with the POC.**

Rationale: The unions provided many examples in our briefs and interviews to demonstrate that the Directives were frequently not detailed enough to address specific work processes. In fact, the unions demonstrated that the work processes of some categories of workers were never addressed specifically in the Directives. Because the unions were not properly consulted, there was no opportunity to raise issues specific and critical to job classifications such as admitting clerks, screeners, radiology, dietary, laboratory technologists, etc.

- h) That the MOHLTC/POC develop an effective communication mechanism to ensure that the MOHLTC/POC is informed of worker concerns, complaints, questions, suggestions reported to or received by the MOL about the implementation of the Directives and health and safety issues arising from the Directives. And that POC actions/decisions as a result of information received, be communicated back in a timely fashion to the MOL and affected unions.**

Rationale: During the SARS crisis, there was a critical communication gap between the MOL, which received numerous worker queries and complaints and the POC. For example, there was no obvious communication link in the MOL SARS Protocol (April 2, 2003) between the MOL command centre and the POC to ensure that these concerns were reflected in subsequent Directives.

- i) That the MOHLTC/POC also establish a communication system to allow affected stakeholders such as unions, an effective avenue to provide feedback and suggestions regarding the Directives for example, directly to the MOHLTC/POC.**

Rationale: As demonstrated throughout the unions' submissions to the SARS Commission, neither union had access to an effective avenue to provide feedback about the Directives. Although some consultation did take place during SARS 1, the consultation was insufficient and there was no evidence in subsequent Directives that our input had any effect. Subsequent to the SARS crisis, the MOHLTC has consulted with ONA regarding new Directives and some ONA comments have been incorporated into the Directives. However, to date, the MOHLTC has declined OPSEU's overtures to be included in the process of developing Directives.

- j) That the MOHLTC begin now to develop a strategy to ensure compliance with all MOHLTC Directives currently in force and for the future.**

Rationale: Throughout the SARS crisis, both unions became aware of situations where employers were not complying with parts of the Directives. The POC was also aware of compliance problems as evidenced by communiqués they issued stressing the importance of

compliance. However, there appeared to be no enforcement mechanism or even reporting mechanism when workers or their unions discovered that employers were failing to implement the Directives appropriately.

2. Recommendations concerning Ministry of Labour: Policies and Procedures:

- a) That upon request, the MOL provide its Operations Division Policy and Procedures Reference Manual (the Policy Manual) to a representative of a Trade Union. And that the Policy Manual be posted on the MOL's Health and Safety website.**

Rationale: The Ministry's Operations Division Policy and Procedures Reference Manual give detailed direction to the Inspectors to assist them as they perform their daily work. The Policy Manual governs the inspectors' actions as they deal with work refusals, complaints, investigation of critical injuries and fatalities, relationships with the Medical Officer of Health, infectious diseases, etc. It would be useful for workers and their unions to have access to the Policy Manual so that they would have a better idea of what to expect when an inspector is called and/or comes to the workplace. Both unions now have the current version of the Policy Manual and find it an invaluable resource. Posting it on the Ministry's website would make it accessible to all workers, not only to union members.

During the SARS crisis, since most workers were unaware of MOL policies, they did not know what to expect when they called the MOL for assistance regarding their own health and safety. Workers were not familiar with the existing policies; nor were they aware of the special SARS protocol that the Ministry had issued to deal with SARS related complaints, concerns and work refusals.

In subsequent recommendations, the unions request changes and additions to the MOL policy manual that we believe will improve worker health and safety especially in the health care sector. If these recommendations are implemented, it will be even more important for unions and workers to have access to the policy manual in order for them to understand what to request and to expect from the MOL.

- b) That the MOL significantly increase its proactive inspections of health care facilities.**

Rationale: The unions note the following in the Industrial Health and Safety Program Sector Plan 2003/2004: Trend Analysis for the Health Care Sector: field visit days dropped from 346 in 2000 to 181 in 2002; proactive visits dropped from 673 in 2000 to 408 in 2002; total field visits dropped from 1195 in 2000 to 704 in 2002; and, number of orders issued dropped from 1040 in 2000 to 528 in 2002. This dramatic decline in enforcement activity is not explained by the Ministry. It is unacceptable and must be reversed. (In 2004, the Ministry has increased its proactive inspections of health care facilities. This decision should be reflected in the Sector Plan in future years given the accident, illness and injury rates in this sector.)

- c) That the MOL consult annually with all affected stakeholders prior to the development of its Health Care Sector Strategies.**

Rationale: In recent years the MOL has consulted the Ontario Federation of Labour as it develops all of its sector strategies. However, not all affected unions are affiliated with the OFL. This process should be formalized to include all affected stakeholders with more realistic time frames so that the affected unions have an opportunity to provide useful feedback.

- d) That the MOL Policy Manual be amended to ensure that the Ministry develops and maintains a pool of inspectors and hygienists with training and expertise in health and safety hazards within health care facilities. And that the MOL increase the size of its Inspectorate accordingly, to ensure that this objective is met.**

Rationale: One of the problems faced by the Ministry inspectors was that they received no specific training to prepare them for enforcement activities in the health care sector. Historically, there had once been some debate about creating a group of inspectors and hygienists with special expertise in the health care sector, but this proposal was never implemented. Recently the unions have learned that the Ministry has offered additional training provided by the Health Care Health & Safety Association to better prepare inspectors to address health care specific health and safety issues. This is a positive step.

However, it is the unions' position that it would be much more protective to develop a pool of inspectors and hygienists who because of specialized training and ongoing experience in the health care sector, could deal quickly and competently with the unique and serious hazards found in the sector.

One compelling reason for this is that health care workers are known to be reluctant to complain to the Ministry of Labour about workplace hazards and to exercise their right to refuse under the Act. Specialized inspectors who make proactive visits to health care workplaces must be able to identify hazards and violations of the Act and regulations, even if workers have not complained about them.

Currently, workers with a limited right to refuse cannot refuse if their refusal would directly endanger the life, health or safety of another person. If, for example a health care worker on a unit refuses to work because their personal protective equipment has not been properly fitted, other workers faced with the same hazard may be prevented from refusing because additional work refusals could endanger patient safety.

Thus the rights of these workers to a safe and healthy workplace are threatened by this legislative limitation. Consequently, there is a heightened responsibility for the MOL and its inspectors to respond quickly and knowledgeably when HCWs complain to the Ministry or exercise their right to refuse unsafe work. The unions will later argue for changes to the Act dealing with work refusals. However in this proposal we are simply arguing for a more highly trained group of inspectors and hygienists to ensure that workers rights to a safe and healthy workplace are not limited by an inspector's lack of knowledge and experience.

Additionally, the total number of inspectors should be increased. The number of inspectors employed by the Ministry has been static at approximately 230 since 1995 despite the growth in the economy and the total number of workplaces and workers in the province. In 1992/93, the Ministry's own Position Inventory indicated that the total complement of inspectors was supposed to be 374. As recently as January 2004, the Director of the Ministry's Occupational Health and Safety Branch reported to the OFL that the total complement of inspectors was supposed to be 270. Currently, the Ministry employs 228 inspectors and a hiring freeze is in force. The unions fail to see how the Ministry can effect an appropriate province-wide enforcement strategy with this minimal number of inspectors.

(Just prior to the completion of this document, the Ministry of Labour announced its intention to immediately hire 100 new labour inspectors and that an additional 100 inspectors would be in place within two years. Both unions commend the Ministry for taking this much needed action.)

- e) That the MOL Policy Manual be amended to include a new section that directs MOL inspectors to perform increased regular proactive inspections of health care facilities given the dramatic failures of the IRS during the SARS crisis. The Policy Manual should clearly state that known poor performers will be first to be targeted. The criteria to define poor performers will include: worker and union complaints and concerns raised to the MOL; work refusals; injury/illness reporting data sent to MOL and WSIB regarding critical injuries, fatalities, lost time and no lost time data; known key hazards; and, WSIB information of known poor performers based on accident frequency, cost, NEER surcharges and Workwell Audit information.**

Rationale: Although the Ministry currently relies on some indicators to identify 'poor performers,' the definition is not sufficiently broad and will miss facilities that have complaints but no work refusals. HCWs have a limited right to refuse unsafe work, are known to be reluctant to complain to the Ministry because they are fearful of reprisals, they are unaware that the OHSA offers them protections or because of a mindset that they are professionals and so should deal with their own workplace problems. Given the high rates of injury, accidents and occupational illnesses in this sector and the number of hazards to which workers are exposed, there is a clear need for increased enforcement activities by the Ministry.

- f) That the Ministry of Labour Policy Manual be amended to clarify the role of MOL inspectors when enforcing the OHSA in the health care sector, especially during an emergency situation, given the sometimes overlapping jurisdictions of MOL and MOHLTC.**

Rationale: For example, during the SARS crisis, the MOL relied on a 1984 agreement between the two Ministries that addressed infectious disease outbreaks for the view that MOL was not required to perform its normal enforcement functions. In the unions' view, the agreement did not relieve the MOL from its enforcement functions. However, in view of the MOL's position, the

policy manual must clarify and define the critical, ongoing role for the MOL to ensure compliance with the Act during an infectious disease outbreak in the workplace.

- g) Where agreements such as the 1984 MOL/MOHLTC agreement exist, all stakeholders must be made aware of the agreement and how it could affect worker health and safety. All such agreements that affect the normal role of the MOL inspectorate should become part of the MOL Policy Manual.**

Rationale: Until the SARS crisis, the two unions were unaware of the 1984 agreement and its potential effect on MOL enforcement activities. In fact, the crisis was well underway before ONA heard the agreement mentioned. OPSEU was never informed of the agreement. Neither union was able to get a copy of the agreement until well after the crisis had passed. It is unreasonable to prevent the workplace parties from having access to an agreement that the Ministry relies on to dramatically change its enforcement activities during an infectious disease outbreak. It is the unions' position that this agreement was inappropriately applied in this case and may have contributed to unnecessary transmission of SARS. If the unions had prior knowledge of the agreement and access to it, we may have had an opportunity to have input into its implementation during the crisis.

- h) If the 1984 Agreement is still in force, it must be revised to clarify that regardless of which Ministry takes the lead in an outbreak investigation, that both ministries will continue to ensure that all applicable Acts are being enforced and that critical injuries and fatalities will continue to be investigated as per the OHSA by the MOL.**

In no circumstances should a Ministry, other than the Ministry of Labour, be permitted to investigate the circumstances surrounding a work-related accident/injury/fatality, occupational illness or critical occupational illness as required by MOL policy and the Act.

Rationale: During the SARS crisis, especially until the first HCW work refusal, the MOL played virtually no visible role and initiated no enforcement activities that the unions were aware of. This was not appropriate and was contrary to the OHSA. It was an unreasonable expectation, if it was an expectation, that Public Health officials would ensure compliance with the OHSA. To our knowledge, Public Health had no mandate to enforce the OHSA, no personnel trained or equipped to enforce the OHSA, and no intention of ensuring compliance with the OHSA; their main role in the workplace was contact tracing. In the opinion of the unions if the MOL had actively enforced the OHSA, unnecessary nosocomial transmission may not have taken place.

One large hospital's JHSC critical/fatal injury investigation reported that the Toronto Public Health Unit played a key leadership and decision-making role in responding to SARS at the hospital. The notion that a key player such as Toronto Public Health might investigate work-related critical illnesses or fatalities as required under the OHSA and Ministry of Labour policy, in our opinion places the Ministry of Health in a conflict of interest position and is contrary to the fundamental principles of natural justice.

- i) In the event of a health care crisis, which leads the MOL to develop a new protocol such as the April 2, 2003 SARS Protocol, such a protocol must be consistent with the OHSA and immediately communicated to all stakeholders.**

Rationale: As the unions demonstrated in our submissions, we were unaware of the MOL SARS Protocol during the SARS crisis and so could not understand why the Ministry workers and supervisors were apparently treating complaints and concerns in a different fashion. As we argued above, it is helpful to unions and to workers to know and understand the rules under which Ministry employees are operating. When the rules are changed, such as they were during SARS, we should have been notified in order that we could advise our members appropriately.

- j) That WSIB and MOL establish a formal program and process to share workplace accident/illness reporting information with each other immediately, once either party has been notified.**

Rationale: Both the OHSA and the WSIA set out reporting obligations for employers to report workplace injuries and illnesses to the Ministry and the WSIB. There is no formal process to ensure that injuries and illnesses reported to one body are also reported to the other. If there was a formal program that obliged the MOL and the WSIB to share injury and illness reports, the MOL and WSIB would have more accurate information and would be able to better enforce reporting requirements set out in the OHSA and the WSIA.

- k) That the MOL amend its Policy Manual to ensure that a communications system be developed in the Health Care Sector which will allow the MOL to communicate with JHSCs:**

- **To distribute notices and other important information;**
- **To gather data and perform surveys; and**
- **To be used in emergency situations**

Rationale: For instance, during SARS, when the MOL finally agreed that probable SARS was a critical injury, this confirmation could have been sent directly to JHSCs to ensure that they could fulfill their obligations under section 9 (31) of the OHSA. As it was, the MOL communicated that information only to the OHA thus limiting the ability of the JHSC to function as it should under the OHSA. If such a communication system existed, the MOL could have distributed its SARS Protocol to JHSCs and its agreement with the MOHLTC – both of these documents would have been helpful to the JHSCs as they conducted their business during the crisis.

- l) That the MOL develop an audit assessment tool that all health care employers must complete in order to determine employer compliance with the *Occupational Health and Safety Act* and Health Care regulation. Such an audit must have JHSC sign off for accuracy.**

Rationale: If we are to change the culture within health care facilities to focus on occupational health and safety, the MOL must begin by assisting employers and JHSCs to determine where the health and safety-related gaps are. Employers must be held accountable to fill those gaps and in the event they resist complying with the Act and developing a health and safety culture, the Ministry of Labour must enforce the legislation and write orders.

- m) That the MOL make it a priority to provide JHSCs with tools and templates to assist them to fulfill their roles as JHSC members and exercise their powers under section 9 of the *Occupational Health and Safety Act***

Rationale: Currently the MOL has few tools available to help JHSC members fulfill their roles and obligations. During SARS, the MOL refused to investigate critical injuries (probable SARS). The JHSC at one large hospital conducted its own critical injury investigation eventually but found it extremely difficult because the Committee had never been faced with this challenge before, lacked the resources to expeditiously initiate the investigation and was denied access to relevant information. For example, the MOL should develop templates and tools such as a Critical injury/illness/accident/exposure investigation template and a JHSC terms of reference tool or model.

- n) That the MOL make it a priority to gather and share best practice documents such as policies, programs, and measures and procedures that could assist JHSCs to assess their own inventory and practices.**

*Rationale: During SARS and after, it was evident that many health care employers (large and small) are not in compliance with the basic requirements of the *Occupational Health and Safety Act* and the *Regulation for Health Care and Residential Facilities* to have written measures and procedures for the health and safety of workers. Due to the minimal time JHSCs have available to them to devote to JHSC activities, they struggle to provide recommendations to employers given the lack of time, skills and resources to support their positions. Developing a best practice database of various types of health and safety-related programs would give them increased ability and confidence to act in their capacity as JHSC members.*

- o) That the MOL enforce the right of JHSCs to fully investigate critical and fatal injuries in the workplace, with full access to all pertinent information and places where the accident occurred.**

Rationale: One large hospital's JHSC investigation of critical injuries (probable SARS) and the fatality of a nurse reported that the employer resisted sharing fundamentally important information such as which patient rooms housed SARS patients.

3. Recommendations concerning the Occupational Health and Safety Act:

a) Amend Section 9 of the Occupational Health and Safety Act to provide:

that workplaces of a certain size with large number of identified hazards must automatically have one worker member of JHSC dedicated full-time to attend to workplace health and safety issues. These workers to be paid by the employer.

Rationale: In many large unionized industrial workplaces, unions have negotiated with their employers to have a member of the Committee dedicated full-time to health and safety issues. Certainly, many large employers including hospital employers have one or more management staff who perform full-time health and safety functions. Yet union-side members of a Committee are by law entitled only to a limited amount of paid time to attend to a short list of legislated functions such as meeting preparation time, meeting attendance, workplace inspections, certification training and critical injury and fatality investigations. Consequently, many dedicated worker members of JHSC perform necessary health and safety activities on unpaid personal time.

The unions believe that this situation limits their ability to function effectively on their Committees as well as negatively affecting worker health and safety. From 1991 to 1995, the now defunct Workplace Health and Safety Agency developed criteria to establish which workplaces required a one, two or three-week Certification training course, based on payroll and number and type of hazards in the workplace. We propose that similar criteria be applied in this case to establish which facilities require a full-time worker health and safety representative.

b) Amend Section 9 (18) of the Occupational Health and Safety Act to provide:

(g) make recommendations for the establishment, maintenance and monitoring of the competency of supervisors, including relevant qualifications, knowledge, training and experience with respect to the work and its performance, the Act and the regulations that apply to the work and any actual or potential danger to the health and safety in the workplace.

Rationale: Documents received by the unions during SARS showed examples of supervisors' lack of competency under the OHSA. It is crucial that the JHSC be involved in making

recommendations regarding supervisor competency as supervisor competency directly impacts the work of the JHSC.

c) Amend Section 9 (22) of the *Occupational Health and Safety Act* as follows:

A committee shall maintain and keep minutes of its proceedings and make the same available for examination and review by an inspector. A constructor or employer shall ensure that relevant occupational health and safety records, including the minutes of the committee proceedings, any written recommendations, any written responses, and any orders from an inspector, are presented on a regular basis to the board of directors, if any, of the constructor or employer.

Rationale: In order to achieve a shift to a safety-based culture, the governing body of a business or facility must view health and safety as a priority. It is the understanding of the unions that in many if not most cases, hospital boards of directors had no idea of the health and safety concerns of their workers during the SARS crisis. Yet, the governing bodies have a duty of due diligence to those who are employed in their facilities.

The requirement to regularly present health and safety minutes and other health and safety documents to a hospital Board of Directors, may also require an amendment to the Public Hospitals Act.

d) Amend Section 9 (33) of the *Occupational Health and Safety Act* to provide:

(1) At the request of either of the co-chairs, an emergency meeting of the committee shall be convened forthwith. In circumstances where the nature or condition of the workplace, including any danger in or around the workplace, may restrict the meeting being held at the workplace, the committee shall forthwith meet offsite or via electronic means, including via teleconference.

Rationale: The documents received by the unions clearly demonstrate the difficulty that JHSC worker members had trying to convene emergency meetings of the Committees during SARS. The inability to convene JHSC meetings may have contributed to the spread of SARS as the JHSC was not able to participate in or recommend preventative measures.

e) Amend Section 25 (1) (b) of the *Occupational Health and Safety Act* as follows:

the equipment, materials and protective devices provided by the employer are maintained in good condition and are of a proper fit for the worker(s) for whom they are provided

Rationale: It must be clearly understood by employers and workers that the employer has an obligation to ensure that equipment, materials and personal protective equipment that workers are obliged to use, provide appropriate protection. If they do not fit workers properly, worker protection will be reduced. This was the case through most of the SARS crisis as workers were provided with respiratory protection, but never fit-tested, nor instructed that fit-testing was an

essential element of wearing the respirators. For more than two months workers wore respirators assuming that they were well-protected from respiratory exposures to SARS; however, once fit-testing was initiated, workers discovered that the masks they had been wearing did not fit them properly.

f) Amend the *Occupational Health and Safety Act* Section 25 (1) to provide:

For the purposes of this Act, including Section 25(1), 27(1) and (2), equipment, materials and protective devices provided by the employer which are not maintained in good condition or which are not of a proper fit for the worker(s) for which they are provided are not and shall not be considered to be:

- i) in compliance with Section 25(1) and Section 27 (1);
- ii) a reasonable precaution for the protection of a worker for the purposes of Section 25 (2)(h) and Section 27 (2) (c);

Rationale: During the SARS crisis, employers and supervisors should have known that workers should not be required to care for SARS patients without masks or properly fitted masks. Supervisors and employers knowledgeable in infection control principles and procedures and in their legislative requirements under the Act and the Regulation for Health Care and Residential Facilities should have ensured that workers' respirators were properly fitted. However, it was evident to the unions that employers and supervisors were unaware of this infection control and legislated responsibility. These obligations are not clearly stated in the legislation and it took us significant time and a work refusal before the Ministry of Labour was willing to clarify the legislative duty. We believe many workers could have been spared exposure if this was more clearly stated in the law. Therefore, it is necessary to set these obligations out more clearly in the Act.

g) Amend section 25 (2) (c) as follows:

when appointing a supervisor, appoint a competent person and ensure that their competency is maintained and monitored during the period of their appointment.”

Rationale: As the Act and Regulations are currently written, there is no clear obligation for employers to ensure that supervisors retain their competency as defined by the Act. Throughout the SARS crisis and still today, both unions are aware that many supervisors that direct the work of our members are not competent under the Act. This situation has been acknowledged this year by the Ontario Hospital Association members of its WSIB hospital Safety Group. The hospital WSIB Safety Group has chosen 'supervisor competency' as a key element upon which to focus its health and safety initiatives in 2004. However, there is no guarantee that the hospitals will continue to focus on this issue in the future. Additionally, as the Act and Regulations, Standards and Guidelines change, the employer has a duty to ensure that supervisors' knowledge is updated.

h) Amend Section 27(2) of the Occupational Health and Safety Act as follows:

(d) ensure that the equipment, materials and protective devices provided by the employer are of a proper fit for the worker(s) for whom they are provided

Rationale: This amendment is proposed for the reasons argued above and simply clarifies that supervisors also have a duty to ensure that the workers they direct have properly fitted personal protective equipment.

i) Amend the Occupational Health and Safety Act Section 43 (1) (a) to provide:

For the purposes of this Act Section 43(1)(a), it is not inherent in the worker's work or a normal condition of the worker's employment to:

- i) work without personal protective equipment
- ii) work with equipment, materials and protective devices provided by the employer which are not maintained in good condition or which are not of a proper fit for the worker(s) for whom they are provided

Rationale: During the SARS crisis, employers and supervisors should have known that workers should not be required to care for SARS patients without masks or properly fitted masks. Supervisors and employers knowledgeable in infection control principles and procedures and in their legislative requirements under the Act and the Regulation for Health Care and Residential Facilities should have ensured that workers' respirators were properly fitted. However, it was evident to the unions that most employers and supervisors were unaware of this infection control and legislated responsibility. These obligations are not clearly stated in the legislation and it took us significant time and a work refusal before the Ministry of Labour was willing to clarify the legislative duty. Many workers could have been spared exposure if this was more clearly stated in the law. Therefore, it is necessary to set these obligations out more clearly in the Act.

j) Amend Section 43 of the Occupational Health and Safety Act to provide:

43(7) (a) Subsection (7) does not apply to those workers whose right to refuse to work is restricted by s. 43(1) and (2).

Rationale for amendment to add s.43(7)(a): Section 43 (7) as it is currently written, allows an inspector to investigate a work refusal "in consultation" with the employer and the refusing worker. It is known that health care workers rarely exercise their right to refuse. We are also well aware of the number and serious nature of the hazards these workers face. It is the unions' position that it is critical, given the above, that an inspector attend at the workplace when a worker with a limited right to refuse exercises that right. It is also critical to ensure that valuable time is not wasted on telephone consultation between the parties instead of investigating and addressing the substance of the problem directly and in person.

43(7) (b) For those workers whose right to refuse to work is restricted by s. 43(1) and (2), an inspector shall investigate any report of a refusal to work or any complaint in the presence of the employer or a person representing the employer, the worker and if there is such the person mentioned in clause (4)(a), (b) or (c).

43(7) (c) The investigation in s. 43(7) (i) (b) shall be conducted by the inspector forthwith.

43(7) (d) Upon receipt of an appeal of an inspector's order, as defined in section 61(5), in respect of any worker whose right to refuse to work is restricted by s. 43(1) and (2) and where delay in the processing of an appeal may endanger the life, health or safety of any person, the Board shall expedite any such appeal and determine the matter after consulting with the parties to the order. The Board shall make rules to deal with any such appeal.

Rationale for amendment to add s.43(7)(b), s.43(7)(c) and s.43(7)(d): Currently there is no recognition in the Act for the types and severity of hazards that workers with a limited right to refuse face in their daily work. In the hospital sector in particular, workers face chemical exposures, exposures to dangerous drugs such as antineoplastics, violence from patients, lifting hazards, working alone, radiation, and more.

Yet when these workers exercise their rights under the Act to do a work refusal, usually their first contact with a MOL inspector is when the inspector commences his/her investigation over the telephone to determine whether the work refusal can be considered valid according to s.43(1) and to MOL policy. If the inspector determines that the work refusal is not valid, then it is downgraded to a complaint and investigated according to the inspector's assessment and timetable.

The unions believe this process further endangers the health and safety of our members, particularly in the hospital sector. It is our experience that our members in the health care sector are reluctant to complain about health and safety to the Ministry of Labour and even more reluctant to consider a work refusal. This experience is supported by MOL inspectors who report that they rarely receive calls for help from this sector, despite the extremely high incidence of compensable injuries suffered by workers in this sector.

The unions also request consideration of serious health and safety hazards, which may affect more than one worker in an area simultaneously. Currently, workers with a limited right to refuse cannot refuse if their refusal would directly endanger the life, health or safety of another person. If, for example, a health care worker on a unit refuses to work because their personal protective equipment has not been properly fitted, other workers faced with the same hazard may be prevented from refusing because additional work refusals could endanger patient safety. In cases such as this, it is even more critical that an inspector investigate the first refusal expeditiously and in person in order to protect the health and safety of all the potentially affected workers.

For additional rationale please refer to decision No. OHS 94-21 that discusses the obligation to investigate expeditiously.

The proposal for the expeditious processing of an appeal of an inspector's order arises from the unions' experience with the timing of s.61 appeals at the Ontario Labour Relations Board. Currently, when an appeal of an inspector's order or lack of order is made to the Board, it may take anywhere from one to two months before a Labour Relations Officer mediation meeting is scheduled. A hearing date may take months after that to be scheduled. In cases where a worker's health and perhaps her life may be endangered by a condition in the workplace, it is more than unreasonable for that worker to have to wait months for a resolution.

k) Amend Section 51 (1) as follows:

Where a person is killed, critically injured or becomes critically ill from any cause in a workplace...

l) Amend Section 51 (2) as follows:

Where a person is killed or is critically injured or becomes critically ill at a workplace...

m) Amend 51 (2) (a) as follows:

saving life, or relieving human suffering or preventing further occupational illnesses;

Rationale for #3 k, l, m: Section 51(1) sets out the employer's reporting obligations to various parties in the case of a critical injury or fatality. It was the unions' experience during SARS that the employer was, in the unions' view improperly, treating work-related SARS as if it was an occupational illness, not an illness of such a critical nature that the more immediate reporting obligations found in s.51 would come into play. In some cases, employers did not even meet their reporting duties for occupational illness as set out in s.52(2).

It is the unions' position that work-related critical illnesses should be treated with the same seriousness as critical injuries and fatalities. Because the Act was developed first for industrial workplaces, legislators and unions may not have been contemplating the possibility of workers being exposed to potentially fatal work-related illnesses. We believe that this shortcoming in the Act should be addressed here as well as in Regulation 834: Critical Injury, proposed later in this document.

The proposed changes to s.51(2) and 51(2)(a) simply harmonize the language with the proposed change to s.51(1) and recognize that the scene of the occupational illness may have to be disturbed to prevent further exposures.

n) Amend Section 52 to provide:

(4) For the purposes of Section 51, "notice to the trade union" shall include notice to any local or subordinate trade union(s) representing workers in the workplace in which the death, critical injury, critical illness occurred and, as well, any provincial or central trade union(s) associated with any local or subordinate trade union(s) representing workers in the workplace in which the death, critical injury, critical illness occurred.

Rationale: During the SARS crisis and after, it was very difficult for the central union bodies to gather information about how many of their members had contracted probable or suspect SARS because of work-related exposures. Although both unions believed that employers had an obligation under existing legislation to provide this information to them, employers disagreed with this interpretation.

It was also very evident during SARS how dysfunctional most JHSCs were. We received reports that employers were not providing reports of SARS or other occupational illnesses to Committees on a regular basis either, clearly ignoring their reporting obligations under s.52. Both unions believe that it is critical that they are notified of all work-related fatalities, critical injuries and critical illnesses from employers in order to assist their local members with investigation, follow-up and prevention activities arising from the incident.

o) Amend Section 52 to provide:

(5) For the purposes of Section 52 and 53, "notice to the trade union" shall include notice to any local or subordinate trade union(s) representing workers in the workplace in which the injury or occupational illness or circumstance set out in section 53 occurred and as well, upon request to any provincial or central trade union(s) associated with any local or subordinate trade union(s) representing workers in the workplace in which the injury or occupational illness or circumstance set out in section 53 occurred.

Rationale: The unions are proposing this amendment because of difficulties we have encountered in the past when we have received a verbal report from a union member about a workplace injury or illness, but are unable to gather detailed information because the employer refuses to provide it to the central union.

Both central unions recognize that we do not need to receive every single report of workplace injuries and illnesses, but we do take the position that from time-to-time, there may be incidents about which we want more information. For example, it may be that one or both unions launch an educational campaign with its health and safety activists to work for change to reduce the incidence of lifting-related injuries. In that case, It would be very useful for the purposes of evaluating the campaign to receive notice from employers for a certain time period of all lifting-related injuries.

The unions believe that we have the right under existing legislation to receive those reports. However, employers and the Ministry of Labour disagree with this interpretation. Therefore, we believe that it is important to clarify reporting obligations in the legislation.

p) Amend section 54 of the *Occupational Health and Safety Act* to provide:

(6) An inspector shall forthwith investigate, in the manner prescribed by the Act, all fatalities, critical injuries and critical illnesses and all refusals to work or complaints of persons whose right to refuse work is restricted by section 43 (1) and (2) of the Act.

Rationale: This proposal reflects a requirement already found in the MOL's Policy Manual which states: "An inspector shall investigate all fatalities and injuries/incidents which raise matters of immediate potential threat to life, limb or health." The unions take the position that MOL delays/lack of critical injury investigations may have contributed to the spread of SARS. It is our belief that this requirement should be set out more explicitly in law in addition to the policy manual in order to stress the importance of the investigation.

This proposal is in harmony with the amendments to s.43(7) above.

q) Amend section 57 (10) (b) as follows:

If the order or report resulted from a complaint of a contravention of this Act or the regulations and the person who made the complaint requests a copy of it, the inspector shall cause a copy of it to be furnished to that person. Additionally, if the worker who made the complaint is a member of a trade union, the inspector shall cause a copy of the order or report to be furnished, upon request to any provincial or central trade union associated with the workers' local or subordinate trade union.

If the inspector's order or report affects workers who are members of other trade unions, the inspector shall cause a copy of the order or report to be furnished upon request, to any other provincial or central trade union.

Rationale: Both unions have encountered situations where an MOL inspector has visited the workplace and left a Premise report with or without orders. In some cases, affected workers in the workplace want input from the central union about the report and an opinion about whether a s.61 appeal should be considered. In some instances, workers do not have access to a fax machine to send the report to the union or they are intimidated by their employer who advises them they have no right to send the report. There are also cases where an inspector's Premise report affects members of more than one union.

Both unions have at different times and with varying success, attempted to get copies of inspectors' reports directly from the inspector or another employee of the MOL. Currently it is not clear in the legislation whether the inspector has any obligation to provide his/her report to a central union upon request. We believe that this proposal will clarify this obligation.

r) Amend section 61 (1) of the *Occupational Health and Safety Act* to provide:

Any employer, constructor, licensee, owner, worker or trade union which considers himself, herself or itself aggrieved by any order made by an inspector under this Act or the regulations or by the failure or refusal of the Ministry or an inspector to carry out the duties of the Ministry under this Act or the regulations may appeal to the Board within 30 days after the making of the order or the alleged failure or refusal of the Ministry or an inspector to carry out the duties of the Ministry under this Act or the regulations.

Rationale: Currently, s.61 clearly sets out the worker's and the union's right to file an appeal of an inspector's order which is defined, pursuant to section 61(5), to include the refusal by an inspector to make an order or decision. However, the Act does not provide a remedy for a worker or a union when for example, the Ministry and/or its agents fails to investigate a complaint, improperly or incorrectly downgrades a work refusal to a complaint, or fails to investigate a critical injury or fatality or to perform any other of the duties of the Ministry as established in the Act. Furthermore, there have been decisions by the Ontario Labour Relations Board, on appeals of inspectors' orders, which have held that that there is no jurisdiction under the Act to make any orders against the Ministry.

In the submission of the unions, this is a serious legislative gap, which weakens the enforcement mechanisms under the Act and undermines the accountability of the Ministry.

The unions believe that this proposed amendment will clarify the rights of workers and unions to an appeal process if they believe the Ministry or an inspector has failed to carry out their duties under the Act and strengthen the remedial powers of the Ontario Labour Relations Board.

s) Amend section 66 (2) to provide that:

finest to corporations under the Occupational Health and Safety Act are similar to those found under the Environmental Protection Act (EPA), section 187-191

Rationale: It is the unions' position that one of the critical principles of an effective enforcement system is that the cost to the employer of violating the Act must be greater than the cost of compliance with the Act. Currently, the fines that are applied under the OHSA are seen by many large employers as the cost of doing business. Increasing their liability should enhance the importance of health and safety in the workplace and enhance prevention efforts. Broadening the sentencing options (similar to those under the EPA) increases the court's ability to engage in creative sentencing to promote a health and safety culture and would be consistent with accepted sentencing goals of general and specific deterrence.

4. Recommendations concerning the Regulation for Health Care and Residential Facilities and Regulation 834 Critical Injury Defined

a) Amend Interpretation and Application Section to provide:

The employer shall ensure that all members of the committee representing the employer and all members representing workers become and remain certified members.

Rationale: It was vividly demonstrated throughout the SARS crisis that many members of the JHSCs did not understand their roles and responsibilities. In some cases, when the worker co-chair of the JHSC tried to call a meeting, some members of the committee were not supportive. They failed to understand the importance of the Joint Committee and the contributions it could make to improve health and safety during the SARS crisis. The unions believe that inadequate training of committee members contributed to this problem.

Health care workplaces are for the most part 24-hour-a-day, seven-day-a-week operations, with a great variety of job functions and exposure to a large number of serious hazards. Workers' compensation statistics demonstrate that there are a large number of occupational injuries and illnesses annually from this sector. Recent pro-active inspections from the Ministry of Labour have also found that in most hospitals visited, health and safety policies and procedures are inadequate and do not meet the minimum standards set out in the health care regulation.

The unions' position is that one factor contributing to the dysfunction of many JHSCs and their lack of activity is that members of the Committees do not have enough training and consequently do not understand their role and their duties under the Act and the regulations.

b) Amend Regulation for Health Care and Residential Facilities (the Health Care regulation) Section 2(1) to provide:

13. Any location where a person is being observed, examined, diagnosed or rehabilitated or is receiving care or treatment.

Rationale: Community health workers face the same hazards as HCWs in facilities, yet they were treated differently during SARS. Currently these workers are not covered by the health care regulation. They must turn to Regulation 851 for Industrial Establishments, if they want more specific regulatory guidance. However, the industrial regulation does not address many of the hazards faced by this group and therefore they must rely on the vague general duty provisions of the Act.

c) Amend Section 9 (1) 2. of the Regulation for Health Care and Residential Facilities as follows:

Safe working conditions, which includes safe staffing levels.

Rationale: Many presenters to the Commission and other SARS investigations suggested that worker fatigue caused by inadequate staffing levels and the burden of wearing PPE may have contributed to the spread of SARS. In reports to the unions and to the Commission, the point was made repeatedly, of how time-consuming and meticulous the procedure of putting on and taking off PPE was for each worker involved. It is the unions' position that there were simply not enough HCWs assigned to SARS patients. At an OHA conference (February 2004), "The SARS Outbreak," one presenter stated that, "Health care worker fatigue was one of the greatest risk factors for contamination."

d) Amend Section 9 (1) 4 of the Health Care regulation:

The control of infections, including emergency and outbreak policies

Rationale: It became clear during the SARS crisis that while most health care facilities may have had infection control policies and procedures to address patient safety, few facilities had developed parallel infection control policies/procedures to meet occupational health and safety requirements under the Health Care Regulation. To some extent, that issue is now being addressed by MOL inspectors who are making pro-active visits to health care facilities and assessing employers' attempts to meet current duties under s.9(1)4 of the regulation.

In addition to the failure of most employers to meet current obligations under the regulation, it also became clear during the SARS crisis that although some hospitals and other health care facilities may have had infection control policies and procedures, they were ill-prepared to deal with occupational health and safety requirements during an emergency situation involving an infectious disease. Existing policies had been developed to deal with infectious diseases such as tuberculosis or blood borne illnesses, but no one, it seemed, had contemplated this kind of emergency. Where policies did exist, it seemed that the expertise did not exist within facilities to expand policies and to apply principles of infection control to occupational health and safety measures to meet the crisis effectively.

The unions believe that the gaps revealed during the SARS crisis can and should be addressed in part by regulatory change to ensure that when infection control measures for occupational health and safety are being developed, that measures for dealing with emergency situations become part of the process.

e) Amend Section 9 of the Health Care regulation to provide:

to include a clause that ensures that all measures and procedures implemented during the course of an emergency/disaster situation are consistent with, and as protective as, all existing regulatory obligations.

Rationale: During the crisis, procedures were developed within facilities without JHSC consultation. In the unions' view, this was improper. In the unions' experience these procedures often did not meet basic requirements set out in the Health Care regulation. The protections

offered to workers by the legislation must remain. In a situation where an infectious disease is the hazard, it is critical to protect workers from exposure, not only for their own safety, but for the safety of patients, other workers and families.

f) Amend the Health Care regulation Section 10 (1):

A worker who is or may be required by his or her employer or by this Regulation to wear or use any protective clothing, equipment or device shall be instructed and trained in its care, use and limitations before wearing or using it for the first time and at regular intervals thereafter and the worker shall participate in such instruction and training.

Rationale: This ensures that workers who may be required to wear protective equipment receive proper training, fitting and instruction for care and maintenance. This should have been happening during the SARS outbreak but was not. It also ensures and clarifies that employers have an obligation to prepare themselves and workers for the possibility of future outbreaks.

During the SARS crisis, and after, some employers have resisted fit-testing and training some groups of workers to ensure that they can work safely wearing a respirator, arguing that only workers in high-risk areas need to be fit-tested and trained. Health care workers in areas not considered high-risk (such as clerical workers in Admitting departments), also developed SARS. In fact, one large hospital's JHSC critical injury/fatality investigation reported that at the hospital, work-related transmission of SARS was confined, "almost exclusively to staff who were not caring for known SARS patients." In health care facilities where patients and workers move throughout the institution, and constantly come into contact with each other, it is almost impossible to state that there are workers who will have no contact with others who may be infectious. It is critical that all employers and workers are prepared in the event of another similar crisis.

g) Amend Regulation 834 – Critical Injury – Defined:

The purpose of this amendment is to include a definition of Critical Occupational Illness in the Regulation in addition to the definition of Critical Injury.

The heading to be amended as follows: Critical Injury/Critical Illness – Defined.

2. For the purposes of the Act and the Regulation, "Critically ill" includes diagnosed with, or suffering from, any illness or disease, including any occupational illness or infectious disease, which may cause or contribute to death, permanent impairment of a worker or which may disable a worker from performing his or her usual work.

Rationale: It is important to include critical illness in this Regulation in order to clearly articulate that a critical illness such as probable SARS, which was eventually accepted by the Ministry of Labour as a critical injury, always falls within the legal definition of critical injury.

There is a benefit in defining critical illness in order to articulate what the employer's legal reporting and response obligations are under the Act. This definition distinguishes critical illnesses from occupational illnesses which also elicit some but not all of the "critical illness" reporting and response obligations. The proposed definition will require the reporting obligations set out in s.51 of the Act.

Much time was spent during the crisis debating with the Ministry whether probable SARS should be treated under the legislation as a critical injury. Had it been defined earlier as equivalent to a critical injury, JHSCs could have initiated their investigations as provided by s. 9(31) of the Act, in a more timely fashion.

5. Recommendations concerning the Workplace Safety and Insurance Act:

a) Amend Section 21 of the Workplace Safety and Insurance Act (WSIA) to provide:

(5) The employer shall give a copy of the notice to any joint health and safety committee(s) established under the Occupational Health and Safety Act at the time the notice is given to the Board.

(6) For greater clarity, and without limiting the obligations under the Occupational Health and Safety Act, the employer shall provide notice of any occupational disease affecting any of its workers in the same manner as it is required to provide a notice of accident.

Rationale: As demonstrated by the unions' submissions, it was extremely difficult during the SARS crisis for JHSCs and unions to obtain information from employers and the MOL concerning which workers had contracted work-related probable or suspect SARS. Employers to our knowledge did not provide this information to the MOL as required by Section 51 and 52 of the OHS Act. Therefore, critical injury investigations afforded to the worker members of the JHSC under section 9 (31) of the OHS Act were initiated in only one facility long after the crisis had ended.

Employers are much more familiar with their reporting requirements under the WSIA and they did eventually provide WSIB with information about work-related SARS illnesses. However, many JHSCs did not receive this information even once it was filed with the WSIB. The intent of these two new sections is to ensure that if one system fails, the JHSCs have another avenue to obtain information necessary to focus on prevention.

6. Recommendations concerning Workplace Safety and Insurance Board Procedures:

a) That in any future crisis/outbreak the WSIB not grant employers an extension on their WSIA reporting obligations.

Rationale: During SARS, the WSIB granted health care employers whose workers had contracted SARS, an extension on their reporting obligations. The unions found that this delay in reporting work-related SARS interfered with the work of the JHSC under section 9 (31) of the

OHSA, to investigate critical injuries and fatalities. Typically, when an employer fills out a WSIB Form 7, it notifies the JHSC of the injury and in most larger facilities provides the JHSC with information contained in the Form 7 or in some cases the Form 7 itself. However, during the SARS crisis, when employers' reporting obligations were extended, notification of the JHSCs was made much later.

- b) That NEER (New Experimental Experience Rating) be revised to incorporate incentives (rebates) only where employers can demonstrate compliance with the OHSA and its regulations, and can demonstrate effective prevention initiatives and return to work programs. In addition, surcharges and rebates must be linked to these same demonstrable health and safety initiatives.**

Rationale: Currently under NEER, an employer can be rewarded with rebates from the WSIB despite having a high incidence of workplace injuries and illnesses and having only made minimal health and safety improvements. The problem is that NEER measures only frequency and duration of an accident and does not measure improvements to health and safety that could prevent similar accidents or illnesses.

It is the unions' experience that many employers have learned to use this system effectively by keeping a worker's wage whole even when they have not returned to full duties. Alternatively, employers can convince workers to accept short term disability rather than WSIB benefits. The effect of the first practice is to reduce the duration of a claim, while the second practice reduces frequency of claims. We have learned from our members that some workers have abandoned their WSIB claims to accept short-term disability benefits which pay more than WSIB's loss of earnings benefit. In these cases, an employer's NEER would not be adversely affected in any way and therefore, there are few financial incentives to encourage employers to make necessary health and safety improvements.

Prior to SARS, if NEER had been structured as recommended above, it is the unions' position that employers may have developed many of the necessary health and safety policies and procedures required by the OHSA and regulations in order to be eligible for a rebate. Had some of these occupational health and safety procedures been in place, the spread of SARS might have been reduced.

- c) That WSIB discontinue its current practice of rewarding poor performers under the WSIB's Safety Program incentive.**

Rationale: The current WSIB Safety Programs offer incentive rewards to participating employers if all participants meet the five chosen initiatives for that year. It is the unions' experience that even poor performers (employers with a higher frequency and lost time rate than others in their industry) are able to benefit financially from the safety programs despite the fact that they may have been surcharged in NEER and are not in compliance with the OHSA.

- d) That WSIB and MOL establish a formal program and process to share and compare (for compliance purposes) accident/illness reporting information with each other immediately once either party has been notified.**

Rationale: Both the OHSA and the WSIA set out reporting obligations for employers to report workplace injuries and illnesses to the Ministry and the WSIB. There is no formal process to ensure that injuries and illnesses reported to one body are also reported to the other. If there was a formal program that obliged the MOL and the WSIB to share injury and illness reports, the MOL and WSIB would have more accurate information and would be able to better enforce reporting requirements set out in the OHSA and the WSIA.

7. Recommendations Concerning Infection Control Measures

- a) That the SARS Commission recommend the creation of a national centre for disease control that would be modeled on the U.S. Centers for Disease Control and Prevention. The mission of a Canadian centre for disease control would be to provide research-based information and education on infectious disease control and prevention for the people of Canada and the development of standards. That all affected stakeholders be involved in the development of any standards, guidelines, best practices and educational materials.**

Rationale: It has been made abundantly clear, from the submissions of the unions, workers and the public to this Commission, in addition to findings of the Walker and Naylor reports, that one of the early and critical failures to deal with SARS was the lack of information, research and a coordinated response that should be made possible if there was a national centre for disease control.

- b) That the SARS Commission recommend that MOHLTC increase funding to public hospitals and Ontario health care facilities, targeted at improving infection control programs within those facilities.**

Rationale: The SARS crisis revealed that many health care facilities lacked effective infection control programs that were flexible enough to accommodate the special measures necessary to deal with an outbreak such as SARS. It was also apparent that HCWs had not received adequate infection control training to be able to safely implement the Directives released by the POC. It is critical that health care facilities are funded appropriately in order for them to implement evidence-based recommendations proven to prevent infection. A vital component of infection control programs must be appropriate training of all health care workers.

- c) That JHSCs are consulted with and have input into the development, review and revision of all infection control policies and programs including training as per Sections 8 and 9 of the Health Care regulation.**

Rationale: Throughout our submissions and those of other individuals and groups to other panels, it has been made abundantly clear that in a health care setting, infection control measures for patients and occupational health and safety measures for workers are, or should be mirror images of each other. It is impossible to have an effective infection control program that does not take into account prevention of infection of caregivers and other workers. Similarly, an effective occupational health and safety program for controlling exposures of workers to infectious agents will be protective of patients.

- d) That the MOHLTC/MOL support the development of standards for Personal Protective Equipment in the health care sector. In particular, that a Respiratory Protection standard for health care workers be developed given that the current CSA Standard Z94.4-02 Selection, Use, and Care of Respirators was developed for application in the industrial sector.**

Rationale: Currently the MOL relies on the CSA Standard Z94.4-02 when considering respiratory protection in the health care sector. However, this standard was developed for application in the industrial sector. The Canadian standard is costly, not readily available and was not developed to protect HCWs from infectious diseases.

The development of a Canadian standard for respiratory protection for health care workers is a critical component for the development of health care facility respiratory protection programs. A Canadian standard will assist employers and JHSCs develop programs in their own facilities.

- e) That supervisors be trained regarding their legislated responsibility to ensure that infection control practices are followed in the workplace.**

Rationale: In our submissions above, the unions have proposed legislative and policy changes to ensure that supervisors are competent under the Act and maintain their competency. It is our position that a critical component of supervisor competency must be an understanding of the principles and practices of infection control. Infection control for patients and occupational health and safety measures for workers cannot be separated without negative consequences to both patients and workers.

- f) That in the future where the MOHLTC develops directives/standards affecting infection control procedures and/or worker health and safety measures and procedures, that this be done in consultation with the unions affected by such procedures.**

Rationale: Throughout our submissions and particularly in the section that dealt with the POC and Directives, the unions argued for the importance of worker and union input into future

directives. We have demonstrated that the Directives developed during the SARS crisis, were often incomplete, confusing and at times ignored some classifications of workers. Subsequent to the SARS crisis, new Directives and Standards have been developed that did have union input; when this input has been reflected in the completed documents, it is the unions' assessment that the standards are clearer and more effective.

g) That all emergency and outbreak policies are consistent with existing infection control measures and procedures as required by the Health Care regulation Sections 8 and 9.

Rationale: It became clear during the SARS crisis that while most health care facilities may have had infection control policies and procedures to address patient safety, few facilities had developed parallel infection control policies/procedures to meet occupational health and safety requirements under the Health Care Regulation. To some extent, that issue is now being addressed by MOL inspectors who are making pro-active visits to health care facilities and assessing employers' attempts to meet current duties under s.9(1)4 of the regulation.

In addition to the failure of most employers to meet current obligations under the regulation, it also became clear during the SARS crisis that although some hospitals and other health care facilities may have had infection control policies and procedures, they were ill-prepared to deal with occupational health and safety requirements during an emergency situation involving an infectious disease. Existing policies had been developed to deal with infectious diseases such as tuberculosis or blood borne illnesses, but no one it seemed had contemplated this kind of emergency. Where policies did exist, it seemed that the expertise did not exist within facilities to expand policies and to apply principles of infection control to occupational health and safety measures to meet the crisis effectively.

h) That the MOHLTC prohibit/discourage the adoption of attendance management programs by employers.

Rationale: Such plans impose pressure on workers to meet arbitrary attendance standards. The SARS crisis reinforced the need for health care workers to remain away from the workplace when they are ill to prevent the transmission of infectious illnesses. Attendance management programs conflict with this basic principle of infection control. The MOHLTC should instead encourage employers to focus on measures to prevent illness and injury in the workplace, and to abandon the regressive, unsafe and unhealthy "attendance management program" approach.

8. Recommendations Concerning Education and New Employee Orientation

- a) That the curriculum of all Ontario institutions that train health care professionals, be revised to contain meaningful and appropriate content concerning occupational health and safety, infection control and emergency/disaster planning.**

Rationale: Currently, it is the understanding of both unions that university and college curriculum for professional HCWs includes no separate modules on occupational health and safety. To accomplish a shift in workplace culture so that attention to occupational health and safety is incorporated into normal business and working practices, it is essential to begin to raise comprehension of and respect for the importance of occupational health and safety while future workers are being trained.

Currently, the burden of all occupational health and safety training lies on the employer. While indeed, it is an employer's obligation under the Act, to warn of hazards and to train workers about the specific hazards in the workplace, it is appropriate also for colleges and universities to take responsibility for laying the groundwork so that new workers are aware of their rights under the OHSA and regulations.

Had this groundwork been laid, HCWs might have approached the unknown hazards presented by SARS with a better understanding of the principles of infection control and that those principles also applied to their own safety.

- b) The unions also request that this Commission consider making a recommendation concerning secondary school curriculum and the need to include meaningful and appropriate content concerning occupational health and safety.**

Rationale: It is the unions' position that in order to achieve a shift to a health and safety-based culture, that exposure to and training in, the basics of occupational health and safety should begin at the time young people are about to enter the workforce for the first time. The frequency and severity of workplace accidents involving young workers have been well-documented by the WSIB and various labour organizations.

Some measures are in place already to provide Young Worker Awareness programs, but it is not a mandatory requirement of secondary school curriculum. It is the unions' belief that if training in occupational health and safety started in secondary school, and was continued in post-secondary education as proposed above, that HCWs would have been better prepared to face the challenges of the SARS crisis.

- c) **That all health care facilities ensure that all new employee orientation includes training concerning health and safety in all measures and procedures as required by the OHSA and applicable Regulations, which includes emergency/disaster planning.**

Rationale: It is the duty of the employer to advise workers of workplace hazards, to develop policies and programs to address those hazards and to provide training to workers in order that they can work safely. In order to comply with these obligations as set out in the Act and the regulations, that process should begin as soon as the worker enters a new workplace.

It is the unions' position that a failure to include health and safety training in a new employee's orientation places an employer out of compliance with the Act and regulations.

This list of recommendations should not be considered exhaustive. We urge Justice Campbell to carefully consider the many useful recommendations found in the reports produced by Dr. David Naylor and Dr. David Walker.

In addition, we request that our health and safety recommendations be considered during the Commission's investigation into any other legislation or regulations. We hope that our submissions and recommendations have raised the Commission's awareness and understanding of the importance of workplace health and safety, so that as you develop a final report and recommendations for change, that a consideration of the impact on workers' health and safety will inform all of your final recommendations and comments.