Ontario

Occupational Health and Safety Branch

Health Care Sector Plan

2010-2011

Safe At Work Ontario

Enforcement > Compliance > Partnership >

Ministry of Labour

ISSN 1923 6239 (Online) I June 2010

Contents

Introduction

Ontario's health care workers are on the front lines protecting patients, residents and clients every day. *Safe At Work Ontario* is the Ministry of Labour's (MOL) strategy for enforcing the Occupational Health and Safety Act (OHSA) and its regulations. As part of *Safe At Work Ontario*, MOL develops annual sector-specific enforcement plans that focus on hazards and outline what inspectors will be looking for during an inspection. This Health Care Sector Plan outlines the ministry's strategy to protect Ontario's health care workers from occupational injury and illness.

There have been substantive updates from the content of the 2009-2010 Sector Plan regarding workplace violence and harassment, and infection prevention and control in health care settings.

A number of statutory and regulatory amendments will come into force during 2010-2011. These include:

- OHSA amendments concerning workplace violence and workplace harassment:
  - *Come into force June 15, 2010.*
- Needle Safety Regulation (O. Reg. 474/07) amendments concerning its application to additional workplaces:
  - *Come into force July 1, 2010.*
- Control of Exposure to Biological or Chemical Agents Regulation (O. Reg. 833/90) amendments including changes to occupational exposure limits for 36 hazardous chemical substances:
  - *Come into force on July 1, 2010*

Please refer to the e-laws website to download a copy of the OHSA and its regulations: www.e-laws.gov.on.ca/navigation?file=browseStatutes&reset=yes&menu=browse&lang=en.

You are encouraged to familiarize yourself with all of the plan contents and to share copies freely with others in your workplace.

Sector plans for other MOL programs may be downloaded from: www.labour.gov.on.ca/english/hs/sawo/sectorplans/index.php.

The health care sector

The health care sector in Ontario is diverse and complex. The table below shows a steady increase in the number of registered health care premises: there was an increase of 973 health care premises, or approximately 17% over the previous four years. From 2006 to 2009, there was an increase of about 10% in the number of registered workers in health care.

Sector size	2006	2007	2008	2009
Registered premises	5,792	6,079	6,429	6,765
Registered workers	480,871	492,967	512,566	529,524

Health care and community care services are provided in a variety of complex settings. There are seven settings covered by the ministry's Health Care Health and Safety Program:

Long-term care homes (nursing homes)
Long-term care homes include extended care residential facilities where continuous nursing and personal care is provided, with medical and professional supervision. Long-term care homes operate under licence from the Ministry of Health and Long-Term Care (MOHLTC).

Homes for residential care (e.g., retirement homes)
Retirement homes provide residential services to individuals who are generally able to care for themselves; however, a variety of levels of care and services are often available. Staff of these operations include nursing staff, personal support workers, and support service staff such as housekeepers and kitchen staff.

Hospitals
Hospitals are the largest employer of workers in the health care sector. Their activities include diagnosis and short-term treatment for patients with a wide range of diseases and injuries. Hospitals vary in the types of services they offer. These include, but are not limited to: general hospitals; rehabilitation hospitals; extended care hospitals; psychiatric hospitals; addiction hospitals; outpost hospitals; paediatric and other specialty hospitals.

Nursing services
Nursing services include agencies providing professional health services (including nursing and medical), other health care services (such as non-professional physical and personal care of clients) and home support services (such as homemaking), on a temporary or long-term basis. Health care personnel whose business activities fall into this group are: dental technicians and hygienists; physiotherapists; health care aides and providers; home care aides and workers; home support workers; and homemakers.

Group homes
Group homes are for residents who require care or support. Residents may have decreased physical or cognitive ability and require supervision and assistance with daily living, or they may require other types of support related to emotional or social well being.

Treatment clinics and specialized services
Treatment clinics and specialized services include: drug and alcohol treatment centres; public health; Community Care Access Centres; community clinics; skills development programs; and childcare settings. Activities include continual assessment and rehabilitative treatment for non-institutional patients whose physical or mental condition is expected to improve.

Professional offices and agencies
Professional offices and agencies include, but are not limited to: doctors' offices; dental offices; other allied health professional offices; and laboratories and specimen collection centres in the community setting. Activities include the private practice of medicine or a specialty of medicine, whether in individual or group practice, by registered physicians and surgeons.

***Note*: Emergency Medical Services (EMS)**
EMS workers and employers should refer to the Industrial Health and Safety Program Sector Plan for transportation for the MOL *Safe At Work Ontario* strategy for EMS: (http://www.labour.gov.on.ca/english/hs/sawo/sectorplans/2009/industrial/industrial_29.php). EMS is supported by the Health & Safety Association for Government Services. (On January 1, 2010, the Education Safety Association of Ontario, the Municipal Health & Safety Association, and the Ontario Safety Association for Community & Healthcare amalgamated to form the Health & Safety Association for Government Services [HSAGS]).

Ministry of Labour compliance focus in health care for 2010-2011

Compliance: intervention based on need

Some businesses require targeted and focused enforcement intervention by MOL up to and including prosecution to deter non-compliance. While these firms are not the majority of businesses in Ontario, the ministry will continue to pay particular attention to them.

Partnerships: a key success factor

MOL is one of several partners in the occupational health and safety (OHS) system in Ontario focused on preventing and reducing workplace injuries and illnesses. OHS system is comprised of MOL, WSIB and the health and safety associations (HSA). The OHS system partners focus on improving workplace health and safety. MOL is responsible for the enforcement of the OHSA and its regulations, the Workplace Safety and Insurance Board (WSIB) focuses on injury prevention and insurance under the Workplace Safety and Insurance Act, 1997, and the health-care-specific HSA, the Health and Safety Association for Government Services (HSAGS), which represents the health care and community care sectors, provides education, training and consulting services.

The Health Care Unit within the Occupational Health and Safety Branch of MOL works collaboratively with its partners such as WSIB and HSAGS to improve health and safety in Ontario health care workplaces.

Additional partnerships have been established with other stakeholders including MOHLTC, the Ontario Agency for Health Protection and Promotion (OAHPP), other Ontario government ministries, agencies, unions, employer associations, occupational health and safety and infection prevention and control professionals and consultants, educational institutions and community organizations.

Working together with its partners, the Health Care Unit continues to develop enforcement and compliance support tools for health care sector workplaces to ensure that health care providers are better prepared for emergencies, including outbreaks of infectious diseases. The following is a brief description of the partners' focus:

> MOL and HSAGS will continue to work together on the development of a range of compliance support tools.
>
> The Health Care Unit will continue to support the Ontario Health Care Health and Safety Committee established under Section 21 of the OHSA. This Committee, comprised of representatives from management and labour, was established to advise and make recommendations to the MOL. The Committee also develops guidance notes concerning the occupational health and safety of health care and community care workers.

Ministry of Labour health care sector initiatives for 2010-2011

MOL's Health Care Unit will focus on increasing workplace compliance with the requirements of the OHSA and its regulations. Below is a brief overview of recent and future partnership strategies aimed at assisting health care workplaces with achieving compliance concerning key occupational health and safety issues.

Musculoskeletal disorders (MSDs)

MSDs continue to be a focus for MOL inspectors. There will be ongoing attention to client handling, particularly regarding worker training, provision and maintenance of equipment, written measures and procedures and supervision. MOL will continue to reference HSAGS's health-care-specific resource material. MOL inspectors will also broaden their MSD focus to examine Joint Health and Safety Committee (JHSC) and Health and Safety Representative (HSR) involvement in preventing and controlling MSDs.

Infection prevention and control

Health care providers are continually at risk from exposure to infectious diseases in the workplace. Employers covered by the Health Care and Residential Facilities Regulation (the Health Care Regulation) under the OHSA are required to develop written measures and procedures in consultation with the Joint Health and Safety Committee (JHSC) or Health and Safety Representative (HSR), if any, to protect the health and safety of workers from exposure to infectious diseases. These measures and procedures should include a hierarchy of controls, including engineering controls, work practices, hygiene practices, administrative controls, personal protective equipment (PPE), and worker training, based on a risk assessment that identifies the hazards.

Health care workplaces not covered under the Health Care Regulation (e.g., retirement homes) require measures and procedures (including, but not limited to, routine practices such as hand hygiene) and worker training based on a risk assessment.

Where workers may be exposed to infectious diseases, MOL will continue to work closely with MOHLTC, OAHPP, the Regional Infection Control Networks (RICN), HSAGS, and other health care stakeholders and partners to ensure that health care workers are protected from infectious diseases.

Needle safety

The Needle Safety Regulation mandates use of safety-engineered needles or needleless devices to replace hollow-bore needles to protect workers from needlestick injuries and blood borne infectious diseases. It currently applies to hospitals, long-term care homes, laboratories and specimen collection centres, and designated psychiatric facilities for all applications requiring the use of a hollow-bore needle. As of July 1, 2010, amendments to the regulation extend its application to all other workplaces in which a worker is to do work requiring the use of a hollow-bore needle **on a person** for a therapeutic, preventative, palliative, diagnostic or cosmetic purpose, which would include:

- Public health units and public health programs;
- Doctors' and dentists' offices;
- Community health centres;
- Ambulance services;
- Health services at industrial and other workplaces; and

- Home care services.

MOL has partnered with HSAGS on the development of compliance tools for the Needle Safety Regulation.

Workplace violence and workplace harassment

Amendments to the OHSA regarding workplace violence and workplace harassment come into force on June 15, 2010. The amendments add new definitions for workplace violence and workplace harassment to the OHSA and will require employers to develop workplace violence and workplace harassment policies and develop programs to implement them. Employers will also be required to assess the risks of workplace violence, and take every precaution reasonable in the circumstances to protect workers from domestic violence that may enter the workplace. To assist health care workplaces with violence prevention strategies, MOL will continue to partner with HSAGS and other stakeholders to develop resources to assist employers with complying with these requirements.

The Internal Responsibility System – fostering a culture of safety

MOL has a primary responsibility to ensure that workplaces comply with Ontario's OHSA and its regulations. This includes ensuring that a strong Internal Responsibility System (IRS) is in place that will foster a sustained culture of workplace health and safety. One of the indicators of a sound IRS is a well-functioning Joint Health and Safety Committee (JHSC), where required.

A strong health and safety workplace culture consists of:

- **Competence** (appropriate knowledge and training, systems for responding to events, properly functioning JHSC and other IRS components;
- **Commitment** (demonstration by the employer of leadership on safety, appropriate policies and procedures to protect workers, low tolerance for poor health and safety practices, insistence upon full compliance); and
- **Capacity** (adequate resources for preventing injuries, a good system for obtaining assistance from HSA and WSIB).

A strong IRS produces a strong culture of health and safety. Strong leadership by senior executives and other managers sets the tone and establishes a corporate culture that nurtures the IRS. A health and safety culture requires all workplace parties to pay constant, appropriate attention to workplace health and safety.

A sustainable workplace health and safety culture needs a strong commitment by everyone to prevent injuries and illness and to reduce risk.

In the health care sector, the development of a strong IRS that can support an organizational culture of health, safety and wellness is the cornerstone of improved staff and client health, safety and wellness and quality of care.

To ensure a strong IRS, MOL inspectors will look for evidence of competent supervision and compliance with OHSA duties of directors and officers of corporations, as described in the Enforcement Focus outlined below.

Enforcement focus: targeted enforcement to maximize impact

Injury and illness trends

For the *Safe At Work Ontario* strategy in the health care sector, MOL's Health Care Unit obtained input from the WSIB and HSAGS to identify workplaces for proactive inspections by MOL inspectors.

Under the strategy, the occupational health and safety injury and illness record of a company is one of the many factors that will identify a firm for MOL inspection. Hazards (often inherent in the work) and the compliance history are other selection criteria.

In addition to proactive inspections and consultations under the *Safe At Work Ontario* strategy, MOL also conducts reactive investigations and carries out hazard-specific heightened enforcement campaigns.

The injury trends and program enforcement activity data within the health care sector are summarized below.

The health care sector has the fourth highest rate of lost-time injuries (LTI) in Ontario, after transportation, forestry and farming. With an average LTI rate per 100 workers of 2.01 in 2008 (HSAGS Data 2009), its LTI rate is higher than in many industrial sub-sectors and the mining and construction sectors. However, it has decreased from 2.06 per 100 workers in 2007 (HSAGS Data 2009).

For the health care sector, MSDs not related to client handling (29%) and MSDs related to client handling (24%) accounted for over half of the LTIs. Among other causes of LTIs were slips and falls (18%), contact with, or being struck by, objects (10%), exposures (7%) and motor vehicle accidents (2%) (HSAGS Data 2009).

Based on WSIB LTI cost data, the five most costly injuries in the health care sector in descending order are:

1. overexertion;
2. falls on same level;
3. bodily reaction;
4. bodily reaction and exertion not elsewhere classified; and
5. assaults, violent acts, harassment.

The no-lost-time injury (NLTI) – a work-related injury that does not result in lost time from work – rate in the health care sector was approximately 3.26 per 100 workers in 2008 and 3.24 in 2007 (HSAGS Data 2009).

When reviewing occupational injury and illness data, MOL inspectors encourage workplaces to establish and enhance a robust workplace health and safety culture. They also consider the contributing workplace hazards while conducting field visit activity to enforce the OHSA and its regulations (such as the Health Care Regulation and the Needle Safety Regulation).

The table below quantifies the health care program activity from 2006 to 2009 (MOL Data 2009). A trend analysis shows the number of workplace visit days, number of inspections, investigations and consultations and number of compliance orders issued. The investigation data ("events") are further broken down into the number of fatalities, critical injuries, work refusals, complaints and other incidents.

Program Activities	2006	2007	2008	2009
# Workplace visit days[1]	739	992	1,160	1,018
# Pro-active visits[2]	1,494	2,279	2,552	2,117
# Field visits	2,324	3,243	3,743	3,383
Inspections	1,464	2,231	2,507	2,073
Consultations	30	48	45	44
Investigations[3]	830	964	1,191	1,266
# Orders issued	3,067	4,530	4,517	3,855

Events	2006	2007	2008	2009
Complaints	271	314	334	327
Work refusals	6	7	1	7
Fatalities	1	0	0	2
Critical injuries	59	65	78	102
Other incidents	90	87	134	513

Investigations have increased steadily from 830 in 2006 to a high of 1,266 in 2009.

During the four-year period beginning in 2006, there were three work-related fatalities of health care sector workers, two occurring in 2009. The number of critical injuries to health care sector workers has increased 73% from 2006 (59) to 2009 (102). These are reported injuries; some workplaces may not report all injuries that meet the definition of critical injury. Additionally, the increase may be due to the enhanced MOL focus on employer reporting of critical injuries as the OHSA requires.

Complaints increased from 271 in 2006, to 314 in 2007, to 334 in 2008, dropping to 327 in 2009.

[1] Workplace visit days is the total duration of time spent by all participating inspectors during inspector field visits

[2] Pro-active visits include inspections made under the *Safe At Work Ontario* strategy, and consultations.

[3] Investigations are reactive workplace visits, which include complaints, work refusals, fatalities, critical injuries and other incidents.

During a workplace visit, a written order is one of the enforcement tools the MOL inspector may use. The three most frequently issued orders issued by MOL inspectors in health care in 2009 concerned:

1) employer obligation to take every precaution reasonable in the circumstances for the protection of workers;

2) employer duty to provide information, instruction and supervision to workers to protect their health and safety; and

3) Material Safety Data Sheets (MSDS) for controlled products in the workplace. (Controlled products are also referred to as Workplace Hazardous Materials Information System [WHMIS] products).

In 2010-2011 MOL inspectors will continue to focus on health care sector specific hazards while auditing compliance with the OHSA and its regulations in general and encouraging workplaces to foster the IRS as part of the workplace's health and safety culture.

Special enforcement focus for 2010-2011

For 2010-2011, MOL inspectors will focus on the following four specific areas: supervisory competency; responsibilities of directors and officers of corporations; effectiveness of JHSC and HSR; and heighten enforcement campaigns (blitzes).

Supervisor competency

This strategy sets the following criteria for competency: appropriate knowledge and training; systems for responding to workplace concerns and events; properly functioning HSR and JHSC; and other IRS components. MOL inspector attention will be focussed on the competency of supervisors.

Competent supervision is an important part of workplace safety culture and the IRS, both part of the ministry's enforcement focus this fiscal year. MOL inspectors will consider whether competent supervision is present in workplaces as an indicator of an effective IRS.

The OHSA defines a supervisor as a person who has charge of a workplace or authority over a worker. For example, a charge nurse may be a supervisor.

Under clause 25(2)(c) of the OHSA, when appointing a supervisor, an employer must appoint a competent person. The OHSA defines a competent person as someone who is qualified because of his/her knowledge, training, and experience to organize the work and its performance, familiarity with the OHSA and its regulations that apply to the work and knowledge of any potential or actual danger to health or safety in the workplace.

The OHSA also sets out certain specific duties for workplace supervisors under section 27, including:

- advising a worker of any potential or actual health or safety dangers known by the supervisor;
- taking every precaution reasonable in the circumstances for the protection of workers;
- ensuring that a worker works in the manner, and with the protective devices, measures and procedures required by the OHSA and its regulations; and

- ensuring that a worker uses or wears the equipment, protective devices or clothing required by the employer.

Responsibilities of directors and officers of corporations:

Under section 32 of the OHSA, directors and officers of corporations shall take all reasonable care to ensure the corporation complies with:

- OHSA and its regulations;
- orders and requirements of MOL inspectors and MOL Directors; and
- orders of the Minister.

Effectiveness of JHSC and health and safety representatives (HSR)

Workplaces that regularly employ six to 19 workers and have no JHSC must have a HSR, selected by the workers from those workers who do not exercise managerial functions at the workplace. The HSR must inspect the physical condition of the workplace monthly. A HSR has the power to identify potential hazards to workers, and to make recommendations to the employer.

JHSCs are required at workplaces that regularly employ 20 or more workers, to which a Designated Substance Regulation applies, where an order has been issued under section 33 of the OHSA (concerning toxic substances) or where the MOL orders a JHSC. JHSC is composed of one or more representatives of the employer and of the workers. At least one employer member and one worker member are to be certified as JHSC members. Like a HSR, the committee has the power to identify sources of danger to workers and make recommendations to the employer. A worker member of the JHSC is to inspect the physical condition of the workplace monthly. The JHSC is to meet quarterly and maintain minutes of the meetings.

You are encouraged to download the MOL Guide for Joint Health and Safety Committees and Representatives in the Workplace for additional information: www.labour.gov.on.ca/english/hs/pubs/jhsc/index.php.

Health care heightened enforcement campaigns (blitzes)

Throughout the year, MOL will also conduct heightened enforcement campaigns focusing on specific hazards to reduce injuries and illnesses in the health care sector. The campaigns will be announced during the year. You are encouraged to visit the Ministry's web site frequently for updated information: www.labour.gov.on.ca/english/hs/sawo/blitzes/index.php.

During these campaigns all workplaces should evaluate their workplace specific policies, measures and procedures, and worker training related to the specific subject matter of the campaign. This may include (but is not limited to) reviewing and updating the health and safety policies and programs, risk assessments and implementation of control measures related to mitigating or eliminating the risk, and developing a continuous improvement plan to correct deficiencies.

The Health Care heightened enforcement campaigns for 2010-11 include: new and young workers (May to August 2010); MSDs (September and October 2010); and loading docks (February 2011).

Health and safety characteristics of the health care sector

The health care sector faces some challenges which may have significant impact on worker health and on LTI rates. These include, but are not limited to, increased care requirements resulting from the aging of Ontario's population, increased patient and resident needs, increased obesity rates, increased demand on community and health care services, globalization of occupational health and safety issues such as emerging infectious diseases, pandemics and other environmental health risks. In addition, employers face recruitment and retention challenges, an aging workforce, a reduction in skilled professional staff, and an increase in casual and part-time workforce.

With Ontario's aging population, there is growing demand for long-term care and residential care services. The demand for long-term care admission may impact workers' injuries (such as MSDs) in retirement homes, because residents may be staying longer in residential care despite their need for higher level care.

The "aging-in-place" philosophy may increase demand for nursing and home support services in the community. Care and support services provided in clients' homes may have an impact on occupational injuries and illness because more workers would be in uncontrolled environments usually away from supervision, and in workplaces not typically built for, or physically able to accommodate, many care activities. In such settings, this can adversely affect worker health and safety in areas such as MSDs, violence, and infection prevention and control, as staff are required to care for residents with more severe illnesses and, in some cases, decreased cognitive ability (i.e., dementia). In addition, workers providing nursing or home support services face greater potential for injury from motor vehicle accidents as they travel from one client to another, sometimes over long distances or in inclement weather.

Group home settings face challenges to provide services to clients. Like the health care sector as a whole, they must balance the provision of appropriate quality care to clients and families with the health and safety of staff providing that care. This is coupled with the challenge of providing staff with appropriate education, training and equipment to provide care safely and the need to maintain a home-like setting for clients.

Hospitals continue to face increased demand on services, providing quality care for complex health needs, while balancing the need for the protection of health care workers.

In an effort to ease the demand on acute care services there is also an increase in the use of community-based health care and treatment clinics, physician practices, and other health care services.

Health and safety hazards inherent in health care work

Risk assessment of health and safety hazards is the process of a qualitative and/or quantitative determination of the likelihood of adverse effects resulting from exposures to hazards. Risk assessment helps in identifying hazards, developing control programs and advising workplace parties of hazards. Measures and procedures for controlling hazards should be developed after assessing risks in consultation with the JHSC or HSR.

WSIB data show that the major hazards which continue to cause the greatest number of LTIs include repetitive, forceful or awkward movements; contacting or being struck by objects; slips, trips and falls; exposures; workplace violence; and motor vehicle accidents. Construction, mechanical and other

industrial hazards are also common to health care settings and must be considered and addressed appropriately. For more information, see the Major Hazards and Inspection Focus table on page 15.

Musculoskeletal disorders (MSDs)

MSDs are pains and strains caused or aggravated by work. In 2008, MSDs continued to be the leading cause of injuries in the health care sector, accounting for 53% of all injuries (4,778 LTI claims). MSDs resulting from lifting, transferring and repositioning patients/residents accounted for 24% of the total LTIs in health care. MSDs from non-client handling tasks accounted for 29% of all LTIs in health care.

Since 2003, the total number of lost-time claims in health care settings has declined by 12%; however, the number of MSD claims has declined only 6% during this period.

Slips, trips and falls hazards

Slips, trips and falls account for the second highest proportion of injuries in health care, accounting for 18% of LTIs in 2008. This resulted in over 1,662 LTIs to workers in the health care and community services sector.

Contact and struck-by-object injuries

Contact/struck-by-objects injuries can involve issues such as material handling, machine guarding, lock out and tag out. Injuries to workers resulting from contact with, or being struck by, equipment, machinery, devices and other objects accounted for 10% of LTIs in 2008 (875 injuries).

Workplace violence hazards

Health care workers are at an increased risk of exposure to workplace violence owing to factors, such as working in the community and private residences, working alone, providing direct care to patients/residents with cognitive impairments, and working with the public. Violence accounted for more than 652 LTIs in health care in 2008, 7% of all LTIs in the sector.

Exposures to biological, chemical and physical agents

Occupationally acquired infections are included in WSIB LTI data as “exposures”; however, there may be many exposures to infectious biological agents that are not reported. More information on occupationally acquired infections is provided under “Infectious diseases” below.

In 2008, 7% of LTIs in health care resulted from exposure to biological, chemical and physical agents in the workplace (620 injuries).

Hazardous biological, chemical and physical agents associated with health care facilities include: fungal spores/mould, viruses, bacteria; nuisance dust, asbestos; laboratory chemicals; hazardous drugs such as anaesthetic gases and antineoplastic drugs; and sterilizing, disinfecting and cleaning chemicals. Hazardous biological, chemical and physical agents associated with renovation or construction in health care workplaces include fungal spores/mould, nuisance dust, asbestos, odourous chemicals, noise and vibration.

Airborne contaminants produced during a procedure may include biological (live viruses/bacteria and other blood-borne pathogens) and chemical (aerosols/particulates and gaseous) agents. One example is a surgical laser plume produced with the thermal destruction of tissue.

Infectious diseases

Workers in the health care sector may develop disease through potential exposure to infectious materials, body substances, contaminated medical supplies/equipment and contaminated environments. Transmission of infectious diseases occurs through direct or indirect contact, droplet and airborne exposures.

Occupational infections in workers, acquired as a result of workplace exposures, meet the definition of occupational illnesses under the OHSA. The nature of the illness must be reported to the MOL, HSR or JHSC, and trade union (if any). In addition to isolated cases of worker infections, outbreaks of illnesses within workplaces that provide care or services to clients occur every year and often involve workers among those infected. Occupationally acquired infections represent a particular concern in the health care sector because data suggest that they continue to occur frequently as part of common outbreaks of illnesses within workplaces in the sector.

Needle and sharps injuries

Needles and other sharps are sources of injuries and potential exposure to infectious agents. Employers are responsible for assessing the risk of sharps injuries to workers and implementing appropriate control measures.

Transportation hazards (motor vehicle accidents)

Although this hazard represents a smaller portion of LTIs in the health care sector, it is significant in that it has resulted in work-related motor vehicle fatalities to workers. Motor vehicle accidents accounted for 2% of LTIs in the health care sector in 2008 (HSAGS Data 2009), resulting in about 200 LTIs.

Major hazards and inspection focus

As part of the *Safe At Work Ontario* strategy, MOL inspectors will give special focus to certain sector-specific workplace hazards. However, inspectors will continue to ensure overall compliance with the OHSA and its regulations, such as the Health Care Regulation and the Needle Safety Regulation (O. Reg. 474/07).

Inspectors will emphasize the role of HSR and JHSC in addressing an organization's hazards and prevention efforts. Inspectors will use organizations' LTI history, field intelligence and information provided by workplace parties to inspect and pay attention to the presence of the following hazards:

Major hazards and key health & safety issues	MOL Health Care Health and Safety Program inspection focus
Asbestos	The Regulation Respecting Asbestos on Construction Projects and in Buildings and Repair Operations, (O. Reg. 278/05) continues to be a focus, particularly in older health care facilities that may have asbestos-containing material (ACM). An asbestos management program must be in place where ACM is present in a building and measures and procedures (e.g., for Type 1, Type 2 operations) must be followed when the building (that contains ACM) is undergoing renovation/construction.

Major hazards and key health & safety issues	MOL Health Care Health and Safety Program inspection focus
Construction hazards	Construction (including renovations, maintenance and new construction) in health care facilities is common. One example is asbestos removal. Therefore, health care facilities need to protect the health and safety of their employees by having a comprehensive plan during a construction project. The plan should include pre- and post-construction risk assessment and hazard communication, including infection prevention and control measures and procedures during construction and renovation. As an employer, the health care facility has the duty to ensure that the measures and procedures prescribed are carried out in the workplace as outlined in clause 25(1) (c) of the OHSA.
Contact and struck-by-objects	Employers are responsible for assessing the risk to workers and developing and implementing measures and procedures for their protection. Compliance with clause 25(2) (a) of the OHSA, requires workers to receive information, instruction and supervision regarding safe work practices and conditions.
Emergency preparedness and response	Emergency preparedness and emergency response plans should include measures and procedures for the health and safety of workers, including training programs. The employer should conduct a risk assessment to develop emergency measures, procedures and training (e.g., influenza pandemic preparedness and response for health care workplaces).
Exposures to chemical, biological and physical agent hazards	Employers must minimize health care workers' exposure to hazardous agents and drugs by ensuring the following: • availability of MSDS (where applicable); • appropriate procedures for safe use, handling and storage of hazardous agents and drugs, worker education and training; • appropriate Personal Protective Equipment; • emergency response procedures; • proper maintenance of anaesthetic gas scavenging systems, including monthly inspection for leakage; and • availability of control measures such as biosafety cabinets for the preparation of antineoplastic agents. Inspections will focus on ensuring compliance with the OHSA and regulations, including the Workplace Hazardous Material Information System (WHMIS) Regulation (Regulation 860/90), Designated Substances Regulation (Reg. 490/09, when it comes into effect on July 1, 2010), Control of Exposure to Biological or Chemical Agents Regulation (Regulation 833/90), and the Health Care Regulation, which addresses anaesthetic gases and antineoplastic agents in sections 96 and 97.

Major hazards and key health & safety issues	MOL Health Care Health and Safety Program inspection focus
Infectious diseases	The focus is to ensure compliance measures are in accordance with the OHSA, and sections 8 and 9 of the Health Care Regulation for workplaces covered by the Regulation. Workplaces in which the Health Care Regulation applies are required to have in place written measures and procedures to protect the health and safety of workers, including protection from exposure to infectious diseases. Consultation with JHSC or HSR on developing those measures and procedures and in providing worker training are required. Employers in workplaces not covered by the Regulation are required under the OHSA to (i) provide information and instruction to workers to protect their health or safety and (ii) take every precaution reasonable in the circumstances for the protection of a worker. These duties would apply with respect to the hazard of infectious diseases. Whether or not the Health Care Regulation applies to the workplace, infection prevention and control measures, procedures and training should be developed following a thorough risk assessment.
Material handling equipment	Material handling equipment must be thoroughly examined by a competent person and clearly marked with the maximum rated load. Workers must be trained in their use before operating. Employers must ensure compliance with the OHSA and its regulations, including clause 44(e) and sections 75 through 79 of the Health Care Regulation.
Mechanical and other industrial hazards	Common industrial-type hazards found in health care workplaces include, but are not limited to, machines, equipment, confined space and restricted spaces, falls related to working at height, and energy hazards requiring lock-out/tag-out systems in place including, electrical, pneumatic, hydraulic or kinetic energy. Each requires hazard identification through a risk assessment so that the employer implements corrective action, including developing and implementing control measures, procedures, training and education.
Musculoskeletal disorders (MSD) (non client handling)	Inspectors will emphasize the role of HSR and JHSC in addressing organizations' MSD hazards and prevention efforts as well as a specific focus on the safe use of carts throughout the various departments within health care organizations. Inspectors will use organizations' MSD injury history, field intelligence and information provided by workplace parties to inspect for the presence of MSD hazards for workers who support direct care. Employers should be aware of their organization's MSD injury record and the presence of MSD hazards. They must take appropriate action to protect workers from MSD hazards. This may include developing written measures and procedures, providing and maintaining equipment, and providing information, instruction and supervision on MSD hazards and the protective measures put in place.

Major hazards and key health & safety issues	MOL Health Care Health and Safety Program inspection focus
MSDs specific to client handling	Inspectors will emphasize the role of the HSR and JHSC in addressing an organization's MSD hazards and prevention efforts and will focus specifically on client handling. Inspectors will use an organization's MSD injury history, field intelligence and information provided by workplace parties to inspect for the presence of MSD hazards in direct patient/resident care. Client handling injuries contribute close to half of all MSD in the health care sector. Employers and supervisors must be diligent in ensuring that staff have equipment available to assist them in moving clients and that they are trained in its use. Employers in consultation with JHSC or HSR must establish written measures and procedures including but not limited to: assessing clients' mobility status, communicating the acceptable client handling technique and how to perform the technique
Needle safety	In Ontario, the Needle Safety Regulation (O. Reg. 474/07) mandates the use of safety-engineered needles or needleless systems to replace hollow-bore needles to protect health care workers from needle-stick injuries in hospitals and all long-term care homes, laboratories and specimen collection centres. The regulation will be extended in July 2010 to cover any worker using a hollow-bore needle on a person for therapeutic, preventative, palliative, diagnostic or cosmetic purposes.
New and young workers	Employers are required to provide all workers with training and supervision. Where there are new and young workers on the job, inspectors will pay special attention to health and safety measures to prevent injuries to this vulnerable group of workers. New workers are those who, regardless of age, have been on the job for less than 6 months or who have been assigned to a new job. Young workers are those 14-24 years of age. For employers in workplaces to which the Health Care Regulation applies, the education and training programs must be developed in consultation with the JHSC or HSR.
Reporting occupational illnesses	Occupationally acquired infections of workers that result from workplace exposures are occupational illnesses that must be reported to MOL, JHSC or HSR and to the trade union, if any, in accordance with the OHSA, subsection 52(2) and the applicable regulations.
Slips/trips and falls	Employers are required to take every reasonable precaution in the circumstances to protect workers, provide information and instruction, and to ensure the workers properly use or wear the required equipment. To decrease potential for slip, trip and fall injuries, inspectors will focus on maintenance of work surfaces, general housekeeping, safe ladder use, etc in accordance with s. 33 through to s. 41 of the Health Care Regulation.

Major hazards and key health & safety issues	MOL Health Care Health and Safety Program inspection focus
Transportation hazards (motor vehicle accidents)	Employers shall assess potential motor vehicle hazards and put in place appropriate measures and procedures in consultation with the JHSC or HSR and ensure worker training to reduce risk of motor vehicle accidents. Employers in consultation with the JHSC or HSR must establish measures and procedures for the maintenance of motor vehicles in accordance with s. 8 and 9 of the Health Care Regulation.
Ventilation maintenance and monitoring	A mechanical ventilation system is required to be inspected every six months by a competent person, and the report presented to the JHSC or HSR. Furthermore, regular maintenance and rigorous preventive and control measures of a mechanical ventilation system, such as a cooling tower, is required to avoid the proliferation or colonization of *Legionella bacteria* in the system. Ventilation is addressed in sections 19 and 20 of the Health Care Regulation.
WHMIS	The WHMIS Regulation contains sections regarding the three core components of the WHMIS program: product labels, MSDSs, and worker education must be in place. In addition, section 42 of the OHSA requires instruction and training, consultation and periodic review of the training instruction. Additional requirements are captured under “Exposures to chemical, biological and physical agent hazards” in this table.
Workplace safety culture and Internal Responsibility System	To promote a strong IRS, employers, when appointing supervisors, are required to ensure that they are competent, as defined by the OHSA. In addition, employers are required to ensure that a JHSC is in place or that there is an HSR when s. 8 of the OHSA applies. A worker member of the JHSC or the HSR must conduct inspections of the workplace in accordance with the OHSA. The JHSC must meet at least every three months and have at least one worker member and one employer member certified by WSIB. Employers in workplaces governed by the Health Care Regulation must develop measures and procedures, training and education in consultation with the JHSC or HSR. The employer must put the measures and procedures in writing and review them at least annually, or more frequently if advised by JHSC or HSR, or if there are changes in circumstances that affect health and safety. Directors and officers of corporations have duties under the OHSA. MOL will concentrate on these aspects of the IRS and workplace safety culture.
Workplace violence and workplace harassment	Amendments to the OHSA regarding workplace violence and workplace harassment come into force on June 15, 2010. The amendments include new definitions of workplace violence and workplace harassment and requirements for employers to develop workplace violence and harassment policies and to have programs to implement them. More information on the MOL’s approach to workplace violence prevention and workplace harassment is available at: www.labour.gov.on.ca.

Summary and highlights

The MOL's Health Care Sector Plan is based on *Safe At Work Ontario,* the MOL's compliance strategy for occupational health and safety. Through proactive enforcement, *Safe At Work Ontario* provides a modern, flexible, compliance-based program. Ontario's health care sector faces a number of health and safety challenges and contributing risk factors as a result of an aging population, increased demand on health care services, and the emergence of multi-factor risks (such as influenza pandemics).

This sector plan contains a brief description of some of the main topics that an inspector may address in the workplace. While each workplace is unique and the circumstances presented to an inspector may result in a different inspection focus, this sector plan provides a general overview of the ministry's focus within health care.

A health and safety culture requires all workplace parties to pay constant, appropriate attention to workplace health and safety, in other words, to have a well-functioning internal responsibility system. Sustainable workplace health and safety culture needs a strong commitment by everyone to prevent injuries and illness and to reduce risk.

For further information contact:

- Ministry of Labour at www.labour.gov.on.ca/english/hs
- Health & Safety Association for Government Services Health Care Team at www.hsags.ca
- Workplace Safety and Insurance Board at www.wsib.on.ca
- Ministry of Health and Long-Term Care at www.health.gov.on.ca/en/default.aspx
- Ontario Agency for Health Protection and Promotion at www.oahpp.ca.